California Grant Application and Annual Report

for the

Maternal and Child Health Services
Title V Block Grant Program

FFY 2014-2015
(October 1, 2014 – September 30, 2015)

Abridged Document

State of CALIFORNIA

Maternal Child and Adolescent Health Program
Center for Family Health
Department of Public Health

Systems of Care Division
California Children's Services
Department of Health Care Services

Table of Contents

State Overview

A. State Overview

California is the most populous state and, in terms of total land area, the third largest state in the nation. Covering over 156,000 square miles California is home to numerous mountain ranges, valleys and deserts. [1]It is bordered by Oregon to the north, Mexico to the south, Nevada and Arizona to the east, and the Pacific Ocean to the west. Depending on how urban and rural areas might be classified, as much as fifteen percent of California could be designated as rural. [2] There are 58 counties in the state with a land area ranging from 47 square miles in San Francisco to 20,053 square miles in San Bernardino. Most counties cover an area greater than 1,000 square miles. The regions with the largest land area include Inyo, Kern, and Riverside Counties. Each of these counties covers an area greater than 7,000 square miles. The smallest regions -- those with less than 600 square miles of land area -- include Santa Cruz, San Mateo, San Francisco, and Amador Counties. [1]

>Population

In 2010, an estimated 39.1 million people resided in California, an increase from 34.1 million in 2000. [3] California's population growth is expected to continue over the next 10 years to reach 44.1 million by 2020. [3] Currently, in 2010, an estimated 42% of the population is White, 37% Hispanic, 12% Asian, 6% African American, 2% multi-race, 0.6% American Indian, and 0.4% Native Hawaiian/Pacific Islander. Trends in the racial/ethnic composition of California's population through 2020 predict a continuing decline in the White population proportion and an increase in the Hispanic population, which will become the largest racial/ethnic group in California. The proportions of other racial and ethnic groups in California will remain relatively stable through2020.

California's diversity is shaped by the multitude of racial and ethnic sub-groups across the state. For example, California's Asian population, the largest in the nation, demonstrates substantial diversity. The largest Asian sub-groups in California are Chinese, Filipino and Vietnamese. Within each Asian group is variation in language and culture. While the largest numbers of Asians reside in the large population centers of Southern California in Los Angeles (L.A.), Orange, and San Bernardino counties, counties with the largest percentage of Asian residents are in the San Francisco Bay Area. [3] Hispanic groups in California are predominantly Mexican (83%), followed by other Hispanic or Latino groups from Central and South America (15%). Less than 2% are Puerto Rican or Cuban. Due to shifts in immigration patterns, an increasing number of indigenous Mexicans have settled in California. [4] While Southern California has the largest numbers of Hispanic residents, at 77%, Imperial County has by far the largest proportion of Hispanic residents in California. In addition, more than 50% of the population in the agricultural counties of Central California is Hispanic. [5] /2012/In 2009, 28.1% or 147,766 of 526,774 births were to foreign-born Hispanic women and 23.2 % or 122,187 of 526, 774 births were to US-born Hispanic women.//2012//

/2013/ > Economy

For 2012-13, the State faces a $15.7 billion budget deficit. To restore fiscal balance, more cuts to state programs and the state workforce were proposed. //2013//

>Age Distribution

In 2010, an estimated 49.4% of the child population 0-18 years of age was Hispanic, followed by White (30.5%), Asian (9.9%), and African American (5.7%). Children identified in multiple race categories were 3.6%. American Indian (AI; 0.5%) and Pacific Islanders (0.4%) made up a small proportion of the overall child population. By 2020, over 52% of children are expected to be Hispanic. The number and percent of Asian children will increase, though not as substantially as Hispanic children. The number and proportion of the White and African American children are expected to decline. Other groups are expected to remain stable. Young children 0-5 years of age are in a particularly sensitive developmental period, and experiences during this time have great influence over subsequent life course health trajectories. The population of children 0-5 years of age has increased from 3 million in 2000 to 3.3 million in 2010, and is projected to reach 3.8 million by 2020. The 2010 racial/ethnic distribution of the young child population was similar to children overall. As with the overall population, proportion of children ages 0-5 who are Hispanic are expected to continue to increase through 2020, while the proportion that is White are expected to continue to decline. Other racial/ethnic groups are projected to remain fairly stable through 2020. [3] In 2010, there were 8.1 million women of reproductive age (ages 15-44) in California. The largest group was Hispanic women (41%), followed by White (37%), Asian (13%) and African American (6%). The percentage of Hispanic women is expected to continue to increase among this age group through 2020 to 47%, and the percentage of White women are expected to decline to 32%. Other groups are expected to remain somewhat stable. Of particular interest are the youngest women of reproductive age, who demonstrate increased risks and poorer birth outcomes compared to their older counterparts., [6], [7] In 2010, there were an estimated 1.5 million females ages 15-19 and 875,000 females ages 15-17 in California. Hispanic females were the largest racial/ethnic group among the 15-19 year olds (47%), followed by White (33%), Asian (10%), and African American (7%). Racial/ethnic distribution was similar among females ages 15-17. /2012/ In 2011, the population of children and reproductive age women increased. Among children and reproductive age women, the Hispanic population proportion increased to 49.8% and 41.9%, respectively, the White population proportion decreased to 30.0% and 36.0%, respectively, and small or no changes were observed in other racial/ethnic groups. [3] //2012//

>Immigration

California is home to 9.9 million immigrants, the largest number and percentage of foreign born residents in the United States. [8]International immigration has accounted for 40% of California's population growth since 2000. Further, since 44.5% of California births are to women born outside the U.S., [9] the well-being of this population has a strong influence on overall MCAH status in California. Most of California's immigrants are from Latin America (56%) or Asia (34%). The leading countries of origin for immigrants are Mexico (4.4 million), the Philippines (750,000) and China (659,000). [9] Immigration status is related to poverty among children in California, which in turn is a strong predictor of health outcomes. Overall, 48% of California's children have immigrant parents; 34% have at least one legal immigrant parent and an estimated 14% have at least one undocumented immigrant parent. Among these children, 24% of children with legal immigrant parents are poor and 38% of children with undocumented immigrant parents are poor. [10] California has the largest number and proportion

of undocumented immigrants of any state. [11] Many undocumented immigrants in California experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits. In 2008, approximately 2.7 million undocumented immigrants lived in California, an increase from 1.5 million in 1990. [11] In 2004, approximately 41% of California's undocumented immigrants resided in L.A. County. [10]

>Languages Spoken

Limited English proficiency (being able to speak English less than ‘very well') poses challenges for educational achievement, employment, and accessing services, and results in lower quality care for immigrant communities--each of which influences MCAH outcomes. Among California's population over 5 years of age, 14.3 million speak a language other than English at home and 6.7 million have limited English proficiency. [8] California's linguistic diversity requires the MCAH system to develop linguistic competence in multiple languages. Among youth in California's public schools, one in four is an English Language Learner (ELL) who is not proficient in English. These 1.5 million students speak 56 different languages, but over 1.2 million of ELL students are Spanish speakers. Other common languages are Vietnamese, Filipino, Cantonese, and Hmong. ELL students reside in every county in California, and in 14 counties in California's Southern, Central Valley, and San Francisco Bay areas, ELL students make up over 25% of the student population. [12]

>Education

In California, one in five individuals over the age of 25 has not completed high school and nearly 10% has not completed 9th grade. Further, measures of educational attainment show that while graduation rates have declined only slightly from 69.6% in 2000 to 68.5% in 2008, drop-out rates have risen sharply from 10.8% in 2000 to18.9% in 2008. [7] Educational attainment varies greatly by race/ethnicity and gender. The 2007-08 dropout rate was higher than the state average for African Americans (32.9%), AI /Alaska Natives (AN; 24.1%), Hispanics (23.8%), and Pacific Islanders (21.3%), and was lower than the state average for Whites (11.7%), Filipinos (8.6%) and Asians (7.9%). [7] California's high school graduation rate for African Americans (59.4%) and Hispanics (60.3%) was substantially lower than for Whites (79.7%) and Asians (91.7%). The graduation rate for females (75.8%) is higher than for males (67.3%) overall, and for each racial/ethnic group. [13] /2012 In 2009, the graduation rate increased to 70%. [7]

>Income

According to the most recent census data, over 4.6 million Californians, 13% of the population, have incomes at or below 100 percent of the federal poverty level (FPL). The 100 percent FPL in 2008 was $21, 200 for a family of four. African Americans, Hispanics, and AI have the highest rates of poverty in California. [14]Among children under age 18 the rate is higher: 16% of the population is in poverty, or approximately 1.6 million children. [15] Projections of child poverty rates through 2012 anticipate that child poverty in California will increase as a result of the recession, peaking at 27% in 2010 before declining slightly to 24% in 2012. In L.A. County, home to 25% of California's children, one in three children is projected to be in poverty in 2010. California child poverty varies tremendously by region. Counties with the highest child poverty rates are in the Central Valley, Northern Mountain, or border regions of California: Tulare (31%), Lake (28%), Fresno (28%), Del Norte (28%), and Imperial (27%). Counties with the lowest rates

of child poverty (below 10%) are in the San Francisco Bay Area, Wine Country, and the Lake Tahoe/mountain recreational area. [15] Only examining the federal poverty level obscures the struggles faced by many families in California because of the high cost of living in this state. An alternate measure of poverty is the self-sufficiency standard, a measure of the income required to meet basic needs (housing, child care, transportation, health care, food, applicable taxes and tax credits and other miscellaneous expenses) that accounts for family composition and regional differences in the cost of living. While 1.4 million (11.3%) of California households are below the FPL, an additional 1.5 million households in California lack adequate income to meet basic needs. [14] [16] Income insufficiency is highest among households with children. Among households with children, 36% of married couple households, 47% of single father households, and 64% of single mother households have insufficient income to meet basic needs. Households headed by single mothers in some racial/ethnic groups have even higher rates of income insufficiency. Nearly 8 out of 10 Hispanic single mother households and fully 7 out of 10 African American single mother households experience income insufficiency. The major financial stressors for households with children are housing and child care; many of these families struggle to meet the most basic needs, cannot afford quality child care, and have limited financial resources to address crises. [16] It is also worthwhile to note that rates of poverty and low income are higher during pregnancy than when measured among children. This means that many more infants are born into financial hardship than statistics on children indicate. [17]/2012/ Poverty among children under age 18 rose to 19.9% in 2009. Another poverty indicator, the percent of public school students eligible for free or reduced price school lunch, increased from 51.0% in 2006 to 55.9% in 2010. [18]While employment grew in 2010, the unemployment rate also increased to 12.4%, the third highest rate in the U.S. [19] Economic recovery has been uneven with some LHJs experiencing continued job losses in 2010. The construction and retail industries experienced continued employment decline in 2010 by more than 10%. [20]//2012//

>Housing

California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health. [21] Lack of affordable housing also forces families to live in conditions that negatively impact MCAH outcomes: overcrowded or substandard housing or living in close proximity to industrial areas increases exposure to toxins such as mold and lead, as well as increased stress, violence, and respiratory infections. [21] It also exposes families to urban deserts, i.e., neighborhoods lacking sidewalks, grocery stores and parks. Even for working families, the high cost of fair market rent is out of reach. In 2010, the fair market rent in California ranged from $672 in Tulare County to $1,760 in San Francisco Bay Area counties. [22] In California, on average, one wage earner working at minimum wage would have to work 120 hours per week, 52 weeks per year in order to afford a two-bedroom apartment at fair market rent. The current foreclosure crisis has greatly impacted California home-owner families. In 2008 and 2009 combined, there were over 425,000 residential foreclosures in California. [23] Foreclosure can force families into lower quality homes and neighborhoods, lead to great financial and emotional stress, and disrupt social relationships and educational continuity. Inability to access affordable housing leads to homelessness for some families. More than 292,000 children are homeless each year in California, which is ranked 48th in the percent of child homelessness in the United States, with only Texas and Louisiana having worse rates among children. [24] Homelessness in children has been linked to behavioral health problems, [21] and negatively impacts educational progress. [24]/2012/ Concerns have increased about the effect of foreclosure on renters and community

members continuing to live in neighborhoods impacted by high rates of foreclosure. In 2010, there were about 170,000 foreclosures. [23] //2012// /2013/ In December 2011, California had the second highest rate of foreclosures in the country. [25] //2013//

>Public Health System

CDPH is the lead state entity in California providing core public health functions and essential services. The Department has five centers to provide detection, treatment, prevention and surveillance of public health and environmental issues. The MCAH Program, the lead entity that manages the Title V Block Grant is housed under the Center for Family Health (CFH). CFH also oversees provision of supplemental food to women, infants and children, family planning services, prenatal and newborn screening (NBS) and programs directed at addressing teen pregnancy, maternal and child health and genetic disease detection. The other Centers within CDPH include the Center for Chronic Disease Prevention and Health Promotion (CCDPHP) which provides surveillance, early detection and prevention education related to cancer, cardiovascular diseases, diabetes, tobacco cessation, injury and obesity; the Center for Environmental Health which is responsible for identifying and preventing food borne illnesses and regulates the generation, handling and disposal of medical waste; the Center for Health Care Quality which licenses and inspects healthcare facilities to ensure quality of care, inspects laboratory facilities and licenses personnel; and the Center for Infectious Diseases which provides surveillance, health education, prevention and control of communicable diseases. To facilitate health planning and coordination and delivery of public health services in the community, California is divided into 61 LHJs, including 58 counties and three incorporated cities. These cities are Berkeley, Long Beach, and Pasadena. In addition to providing the basic framework to protect the health of the community through prevention programs, LHJs provide health care for the uninsured, which may include mental health and substance abuse treatment services. Given the diversity of these LHJs in size, demographics, income and culture, tremendous diversity also exists in how LHJs organize, fund and administer health programs. MCAH allocates Title V funds to LHJs to enable them to perform the core public health functions to improve the health of their MCAH populations. All LHJs must have an MCAH Director to oversee the local program. LHJs must also conduct a community needs assessment and identify local priorities every five years. LHJs address one or more local priorities in their annual MCAH Scope of Work. LHJs must also operate a toll-free telephone number and conduct other outreach activities to link the MCAH population to needed care and services with emphasis on children and mothers eligible for Medi-Cal. Other LHJ activities include assessment of health status indicators for the MCAH population, and community health education and promotion programs. Specific MCAH categorical programs administered by LHJs include the Adolescent Family Life Program (AFLP), the Black Infant Health Program (BIH), the California Perinatal Services Program (CPSP), the Sudden Infant Death Syndrome (SIDS) education and support services, and Fetal and Infant Mortality Review (FIMR). /2012/ CCS addresses the health service needs of CSHCN in the state. These services include diagnostics and treatment, case management, and physical/occupational therapy for children under age 21 with CCS-eligible medical conditions. Larger counties operate their own CCS programs and smaller counties share the operation of their programs with the state CCS regional offices: Sacramento, San Francisco and L.A.//2012//

/2013/The Office of Family Planning (OFP) was moved from CDPH to the Department of Health Care Services (DHCS) effective July 2012. The Teen Pregnancy Prevention Programs under OFP,

including the I&E Program and the California Personal Responsibility Education Program (CA PREP) will move to MCAH. Currently, MCAH is actively implementing CA PREP. Additionally, the Governor's budget proposes the development of the Office of Health Equity under CDPH, which will consolidate multiple organizational entities in multiple Human and Health Service agencies.//2013// /2014/ The Office of Health Equity will play a key leadership role to reduce health and mental health disparities to vulnerable communities through the building of cross-sectorial partnerships.//2014// /2013/The Governor established the Get Healthy California Task Force in May 2012 to improve the health of Californians.

> Access to Health Care
In California, 19 percent of the population did not have health insurance in 2009/10, and highest among Hispanics. [7]

> Healthcare Reform
The Patient Protection and Affordable Care Act of 2010 (ACA) created a new mechanism for purchasing health insurance coverage called a Health Benefit Exchange (HBEX). California was the first state to pass legislation to create a HBEX, a quasi-governmental body that follows the "active purchaser" model of benefits exchanges. [26] //2013// /2014/Starting October 2013, Covered California, the state-run health insurance market, will qualify low-income individuals and families for free health insurance through Medi-Cal and moderate-income families to premium subsidies to make private health coverage affordable. It provides consumer protections set forth by the ACA including the ten Essential Health Benefits. //2014// **/2015/ Medi-Cal and Covered California created an online "one-stop shop" for health coverage. By March 2014, Covered California had nearly 1.4 million enrollees and with Medi-Cal expansion, an additional 1.9 million new Medi-Cal enrollees. //2015//**

Major State Initiatives

The process used by MCAH to prioritize and address current and emerging issues impacting the health of the MCAH population through its major initiatives is multifaceted. This process includes monitoring the MCAH population health status, consultation with our stakeholders, collaboration with local MCAH directors, partnering with programs within CDPH and with staff from other departments such as the California Department of Education (CDE), the California Department of Social Services (DSS), the DHCS and Alcohol and Drug Programs (ADP) and with a variety of public health educators, clinicians and organizations concerned with the well-being of the State's Title V populations. The process also includes support of ongoing MCAH priorities and priority needs identified through the needs assessment process. The process includes consideration of public input, alignment with CDPH's strategic plan and priorities, availability of resources and the political will to address these factors. /2012/A more in-depth discussion of the major state initiatives is included as an attachment to this section.//2012// Given this multifaceted approach, California's Title V major state initiatives include the following:

>1115 Waiver, Promoting Organized Systems of Care for Children with Special Health Care Needs (CSHCN)
California's Medicaid Section 1115 waiver for hospital financing and uninsured care expired on August 2010 and provides an opportunity to transform the delivery of health care to children

enrolled in CCS in a more efficient manner that improves coordination and quality of care through integration of delivery systems, uses and supports medical homes and provides incentives for specialty and non-specialty care with a new waiver application.

Pursuant to (Assembly Bill (AB) x4 6, August 2009), DHCS submitted a new and comprehensive Section 1115 Medicaid waiver. This legislation sought to advance two policy objectives in restructuring the organization and delivery of services to be more responsive to the health care needs of enrollees, to improve their health care outcomes, and slow the long-term rate of Medi-Cal program expenditures.

A Stakeholder Advisory Committee consists of individuals representing the populations for whom the delivery of care would be restructured through the waiver design. Reporting to the Stakeholder Advisory Group are technical workgroups (TWG) constructed to discuss each of the populations and make recommendations to DHCS on what could be included in the 1115 Waiver that would improve the delivery of care for CSHCN. The CCS TWG workgroup has assisted in specifically recommending several delivery models to pilot test in order to determine if any one of them can be used to more effectively provide care for CCS clients. The CCS TWG has advised retention of the successful parts of the CCS program including quality standards and the network of providers.

Members of the CCS TWG represent families, provider organizations (American Academy of Pediatrics [AAP-CA], Children's Specialty Care Coalition, California Association of Medical Product Suppliers, and California Children's Hospital Association); County CCS programs and County Health Administrators; foundations and MCMC health plans. The activities of the CCS TWG have been supported by the Lucile Packard Foundation for Children's Health. Specific information on the CCS TWG can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupCCS.aspx.

/2012/The "Bridge to Reform" Section of the 1115 Waiver was approved in November 2010. In April 2011, the Request for Proposal to implement the CCS portion of the Waiver was released seeking applications from qualified entities to develop and administer Demonstration Projects for a group of CCS clients.//2012// /2013/Five projects were selected with four different models of care through which CCS children will have all their health care needs met by a single coordinated health system. Projects have phased-in start dates from June 2012 to 2013 and an evaluation program is under development.//2013// /2014/MCMC, the 1115 Waiver Model, began April 2013 in San Mateo County while the Accountable Care Organization model will begin later in 2013.//2014//

>Child Health Insurance Coverage

State legislation AB 1422, along with funding from the First Five Commission and program savings enacted by the Managed Risk Medical Insurance Board (MRMIB) will allow the Healthy Families Program, (HF), California's low cost insurance for children and teens who do not qualify for Medi-Cal, to continue providing health care coverage to current enrollees.

From July 2003 through December 2009, over 4 million children receiving assessments were pre-enrolled for up to two months of no cost, full-scope Medi-Cal benefits. The number of families utilizing the Child Health and Disability Prevention Program (CHDP) via this process appears to

gradually increase due to the number of families losing private health insurance due to the economy. /2012/ From July 2003 through 2010, over 4.4 million children were pre-enrolled.//2012// /2013/From July 2003 through 2011, over 5.8 million children were pre-enrolled.//2013//

/2014/ The combined HF and Medi-Cal enrollment for fiscal year (FY) 2010 was 6,188,788. The California Health and Human Services Agency (CHHSA), MRMIB and DHCS developed a transition plan for HF enrollees to Medi-Cal. Medi-Cal established the Targeted Low Income Children's Program which expands child eligibility to 250% of FPL. The transition, implemented in phases, began in January 2013. HF will continue to serve families until they are transitioned to Medi-Cal, including Access for Infants and Mothers (AIM)-linked infants. In addition, children continue to be pre-enrolled into Medi-Cal through the CHDP Gateway.//2014// // **/2015/In 2013, HF no longer enrolled new applicants. For details, see HSCI 3.//2015//**

> Obesity
See National Performance Measure 14 and State Performance Measure 6.//2013//

>Breastfeeding
Due to state budget cuts in August 2009, funds were reduced for the Birth and Beyond California (BBC) a hospital-based breastfeeding continuous quality improvement (QI) project which promotes model hospital policies to improve in-hospital exclusive breastfeeding rates. Funding continues for Regional Perinatal Programs of California (RPPC) in L.A. to develop a report on BBC pilot project findings and provide technical assistance (TA) for all other RPPC regions for 2 years. To date, 20 hospitals participated and two RPPC regions obtained other funds to continue the BBC work. BBC curricula and tools will be posted on the MCAH breastfeeding website. /2012/ In addition to the original 23 hospitals that participated in the BBC project, 13 more hospitals have successfully completed this program without the support of CDPH funding. BBC generated national interest and was highlighted at the first California Hospital Breastfeeding Summit held in January 2011.//2012// /**2015/MCAH is an in-kind sponsor of the annual Breastfeeding Summit.//2015//**

/2013/MCAH released the "BBC: A Hospital Breastfeeding Quality Improvement and Staff Training Demonstration Project Report". Curricula, trainer notes, evaluation tools, and other materials for hospitals are posted at http://cdph.ca.gov/BBCProject.//2013// **/2015/Vermont's Breastfeeding Quality Improvement Project adopted BBC to develop an online platform which is shared with the BBC website. //2015//**

MCAH is in the process of releasing 2008 in-hospital exclusive breastfeeding data and will be made available online with links to resources to help hospitals improve their exclusive breastfeeding rate.

In December 2009, MCAH and the Women, Infants and Children (WIC) Supplemental Nutrition Program, in collaboration with the California Breastfeeding Coalition, and the California WIC Association began the California Breastfeeding Roundtable. The Roundtable met for the second time in June 2010 and has drafted a strategic plan that will be used by the CDPH Nutrition,

Physical Activity and Obesity Prevention Program (PAOPP) grant funded by the Centers for Disease Control and Prevention (CDC). MCAH is represented in the US Breastfeeding Committee and be involved in its national promotion of workplace lactation support. MCAH has been advocating for a new CDPH lactation policy and piloting a bring-your-infant to work lactation supportive policy.

CCS is partnering with the California Perinatal Quality Care Collaborative (CPQCC) in a breast milk nutrition QI collaborative for 2010 involving 11 community and regional Neonatal Intensive Care Units (NICUs) with a goal of collaboratively improving by 25% any breast milk at discharge for <1500 gm. infants. The baseline period is 10/1/08 through 9/30/09 and the intervention timeframe is 10/1/09 through 9/30/10. Each NICU has its own goal statement and is also collecting data on process and balancing metrics. In addition to monthly calls and exchanges via e-mail, there are three face-to-face learning sessions in 2010./2012/This Collaborative ended October 2011. The goal of improving by 25% any breastfeeding at discharge for <1500gm infants was met.//2012//

/2013/ WIC and MCAH finalized a web-based hospital breastfeeding policy curriculum for hospital administrators. In 2011, the Infant Feeding Act was passed requiring that all maternity hospitals have an infant feeding policy that supports breastfeeding by 2014.//2013//

/2014/ MCAH /2015/ and SCD //2015// is collaborating with the Office of Emergency Preparedness to develop an infant feeding plan and with Chronic Disease Division to develop breastfeeding-supportive clinics.//2014//

/2015/ MCAH collaborated with the CA Obesity Prevention Program (COPP) on a statewide pilot project focused on increasing breastfeeding duration rates in low- income communities of color. Working with 15 community health centers and an expert advisory committee, recommendations will be published on implementation of model "breastfeeding-friendly" environmental clinic policies/practices, and improved reimbursement policies.

SCD and MCAH provide assistance to the DHCS's Breastfeeding Task Force to increase breastfeeding rates among women receiving Medi-Cal as part of the DHCS Strategy for Quality Improvement. The task force is working with external stakeholders, including MCMC plans, to increase breastfeeding rates. //2015//

>Comprehensive Black Infant Health (BIH) Program assessment
MCAH places a high priority on addressing the persistent poor birth outcomes that disproportionately impact the African American community. MCAH has focused efforts to address social disparities to close the gap--BIH is central in these efforts.

The report recommended the development and implementation of a single core model for all local BIH program sites to enhance the impact on African American infant and maternal health. MCAH convened groups of key stakeholders including local BIH and MCAH staff, state MCAH staff, and UCSF Center on Social Disparities in Health staff to develop various aspects of the revised model and comprehensive evaluation plan. The revised model integrates the most current scientific findings,/2013/lessons learned from our previous model, staff and partner expertise//2013//and state and national best practices. The revised model is strength-based, ensures linkages to prenatal

care, empowers women to make better health choices for themselves and their families, improves their ability to manage stress related to the social, cultural, and economic issues known to influence health, and encourages broader community engagement to address the problem of poor birth outcomes. Services are provided in a culturally competent manner.

The program starts with an assessment of clients' needs and strengths. There is primarily case management based on each client's needs. Central to this model is the 20 session group intervention (10 prenatal and 10 postpartum) that encourages and supports behaviors to help African American women become strong individuals and effective parents. The evaluation and data collection process has been revised to assess the program's effectiveness and has program standards and quality assurance measures to ensure the revised model's fidelity. In June 2010, a panel of national experts that was convened endorsed the concept; felt the model was scientifically supported and made recommendations for refinement.

Training on the new model and pilot implementation was conducted at approximately half of the BIH sites in summer of 2010.

/2012/ In November 2010, 8 of the 15 BIH sites implemented the revised model. Initial qualitative reports indicate that clients are well engaged and find the group intervention positive and empowering. An early assessment finds that sites have found two major issues: (1) state and local administrative and logistical challenges delayed implementation and transition between the former model and revised model, resulting in loss of recruitment sources, and (2) local sites have not changed their recruitment messages to reflect the revised model. MCAH, working collaboratively with UCSF Center for Social Disparities in Health, and local sites are addressing client recruitment. BIH sites will be required to complete a client recruitment plan. MCAH will be transitioning the remaining sites through TA and training, to begin implementation in November 2011.//2012//

/2013/ The revised model was implemented in November 2011. In March 2012, MCAH published the report entitled: Black Infant Health Program Pilot Implementation (Phase I) Preliminary Assessment Report. In 2012, MCAH will conduct site profiles of each LHJ and launch an upgraded management information system//2013// /2014/ (MIS). All profiles were completed and all sites have been trained to use the MIS. Data will be analyzed to generate information for program improvement and evaluation.//2014//

>Preconception Health

While the main goal of preconception care is to provide health promotion and screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies, Implicit in its Preconception Health and Health Care Initiative (PHHI) MCAH employs a life course perspective that promotes health for women and girls across their lifespan, regardless of the choice to reproduce, and recognizes the impact of social and environmental factors on maternal and infant outcomes. MCAH partners with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health and clinical practice, develop policy strategies to support preconception care and promote preconception health messaging for women of reproductive age.

/2012/ The Preconception Health Council of California//2012// (PHCC), established in 2006 through a partnership between MCAH and March of Dimes (MOD), remains at the center of preconception health activities in the state. In May 2009, the PHCC launched a comprehensive preconception health website--Every Woman California. The website features information about health considerations for women of childbearing age --including low-literacy PDFs on 21 preconception health topics -- as well as resources, tools, and best practices for providers. The website has a partner registration feature to encourage networking and resource sharing among those interested in preconception health and health care and features interactive event calendars and discussion forums: http://www.everywomancalifornia.org. /2012/ /2013/It was updated in 2012 and features reproductive life planning (RLP) and new preconception health clinical resources and statewide initiatives.//2013//

MCAH worked to incorporate preconception health messaging by including interconception curriculum content in BIH and the trainer module for California Diabetes and Pregnancy Program (CDAPP)//2012//

Other preconception health activities include a folic acid awareness campaign implemented in early 2009 designed to address Latinas and women of lower education attainment. It featured Spanish language radio Public Service Announcements (PSAs); outreach to the community through health promoter training; and vitamin distribution and education through local public health programs. The campaign resulted in a 1200% increase in calls to referral line and 45,000 bottles of vitamins distributed.

MCAH received the First Time Motherhood grant funds from Health Resources and Services Administration (HRSA)/MCHB to implement a preconception health social marketing campaign. /2012/Data indicated that the lowest prevalence of daily folic acid use was among Latinas, and the lowest prevalence of healthy weight and smoking abstinence were among African Americans.//2012// The project will test "preconception health" and RLP messages in a life course context and message delivery mechanisms, including web-based and mobile-based strategies, with different populations, especially African-American women, Latinas and youth of color. The campaign will also address broader societal influences on health. MCAH will be working on this campaign through early 2011. /2013/PHHI collaborated with AFLP PYD to develop the RLP guiding framework and tool for the client-centered goal setting teen pregnancy prevention program. //2013//

MCAH staff continues to participate in a number of national preconception health-related workgroups including the national preconception health indicators workgroup/2013/, the national expert panel on life course metrics //2013// and the CDC's preconception health consumer workgroup /2014/Show Your Love campaign.//2014//

PHCC is the coordinating hub for preconception health activities across the state such as the Interconception Care Project of California (ICPC), an American Congress of Obstetricians and Gynecologists (ACOG), District IX project funded by MOD that is charged with developing postpartum care visit guidelines for obstetric providers. The project aims to provide physicians with tools to address issues at the postpartum visit that could affect a subsequent pregnancy and counsel the patient about /2012/ways to improve their health status and//2012//plans for future

children. /2013/ICPC guidelines were completed and include English and Spanish provider algorithms and patient handouts on 21 common postpartum conditions//2013// /2014/, with diabetes offered in Vietnamese.//2014// /2013/Providers were informed of its availability and guideline trainings were offered.//2013//

MCAH LHJs have also undertaken activities related to preconception health. The L.A. Collaborative to Promote Preconception/Interconception Care produced a curriculum for public health providers; published a data brief on preconception health in LA County; established a website; held a second preconception health summit for providers in the county; and developed an evaluation framework for the collaborative. It also oversees local preconception health projects that have had promising results such as the California Family Health Council's (CFHC) effort to develop and introduce a pre/interconception care curriculum into nearly 80 Title X clinics and the Public Health Foundation Enterprises WIC's WOW project (WIC Offers Wellness) which extended its integration of interconception health into WIC from one center to 61 centers throughout L.A. and Orange County. /2013/PHHI developed preconception health scope of work objectives and provided technical assistance to MCAH LHJs. State and local MCAH are partnering to implement the federal Office of Minority Health Peer Preconception Health Program in community colleges and universities//2013// /2014/Together with local partners, MCAH trained about 200 Preconception Peer Educators (PPE) in the San Joaquin Valley and developed statewide training and outreach resources online.//2014// **/2015/ The Preconception Health Initiative streamlined its focus on four priority areas: folic acid use, linkage to medical home/well-women visits, family planning and healthy relationships. MCAH developed the social media toolkit targeting year-long messages to young men and women. //2015**//

>High-Risk Infants

The High Risk Infant Follow-up Program (HRIF) screens babies who might develop CCS-eligible conditions after discharge from a NICU and assure access to quality specialty diagnostic care services. All CCS-approved NICUs are required to have a HRIF Program or a written agreement for services by another CCS-approved HRIF Program.

In 2006, CCS redesigned HRIF and started the Quality of Care Initiative (QCI) with CPQCC. The QCI developed a web-based reporting system to collect HRIF data to be used in quality improvement activities. As of March 2010, 60 of the 74 CCS-approved HRIF Programs are reporting on-line, with a reporting of over 2,000 HRIF Program referrals and 1500 HRIF Program visits. /2012/As of March 2011, 62 of the 65 CCS-approved HRIF Programs are reporting on-line, with over 10,860 HRIF Program Referrals/Registrations and 7,181 HRIF Program Standard Core Visits.//2012// /2013/As of February 2012, 65 of 66 CCS-approved HRIF programs are reporting online, with 19,055 HRIF Program Referrals/Registrations and 17,079 HRIF Program Standard Core Visits. The HRIF Executive Committee established a QI workgroup in February 2012.//2013// /2014/As of February 2013, 67 of 69 HRIF programs are reporting online with 5170 HRIF Program Referrals/Registrations and 1550 HRIF Program Standard Core Visits for 2012. HRIF summary reports provide information on the follow-up status of enrollees, demographic/social risk information, status of medical and special service needs, neurological examination outcomes and developmental outcomes. Feedback and reports from HRIF Program staff are obtained in the annual quality audit report.//2014// **/2015/In 2013, 70 of 115 CCS NICUs had HRIF and used a web-based data reporting system. The number of infant**

referrals to a CCS HRIF exceed 33,000. By January 2014, HRIF QCI finalized data reporting system improvements. Each HRIF ensures there is a system in place to follow-up with families to improve adherence to HRIF diagnostic assessments and evaluations. Recent and planned ongoing CPQCC/CCS research includes assessment of site-specific NICU and HRIF clinic challenges and successes.//2015//

>Neonatal Quality Improvement Initiative
CMS and the California Children's Hospital Association (CCHA) sponsored a statewide QI Collaborative, partnering with CPQCC, to decrease Central Line Associated Blood Stream Infections (CLABSIs) in NICUs using the Institute for Healthcare Improvement (IHI) model for QI. Thirteen regional NICUs participated in 2006-07, reducing CLABSIs by 25 percent for all weight groups. In the second year, all 22 Regional NICUs participated, aided by a Blue Shield Foundation grant. The CLABSI rate in 2008 was 2.33 per 1000 line days and 3.22 in 2007, but some of this reduction was due to a CDC definitional change for CLABSIs beginning January 2008. After the grant extension ended in June 2009, 14 regional NICUs continued the CLABSI prevention collaborative and for 2010 they are adding bloodstream infection (BSI) prevention. For 2009, the CLABSI rate for the 14 NICUs was 2.05 for all weights, and competing priorities have been the greatest barrier to infection prevention. /2012/For 2010, the CLABSI rate for all weights had decreased to 0.97, which is a 77% decrease since the inception of the Collaborative in 2006. The Collaborative is continuing in 2011 and will be inviting more Regional NICUs to join.//2012//

/2013/By mid-2011, CLABSI rate decreased another 70% from 2009; for all birth weights combined it has declined to 0.65 infections/1000 central line-days. Participating NICUs are implementing practice policies. To comply with Section 2701 of the ACA, elements of the NICU CLABSI collaborative will be brought to all CCS approved NICUs and Pediatric Intensive Care Units (PICUs) beginning July 2012.//2013// /2014/The collaborative ends mid-2013. It has sustained gains with an overall CLABSI rate of 0.65/1000 central line-days.

CCS began a new NICU CLABSI prevention collaborative that integrates QI routinely. This new collaborative funded by the American Hospital Association is linked to a NICU CLABSI prevention collaborative in 14 other states, Of the 180 NICUs in this national collaborative, 68 are CA NICUs. The ultimate goal is to enroll all 132 CA NICUs in ongoing QI projects led by CCS.//2014//

/2015/The multi-year collaborative ended in 2013 with an overall CLABSI rate of about 1 per 1000 central line-days. CCS is working with neonatology and hospital organizations to develop core curriculum on safety, reliability, and process improvements to eliminate NICU CLABSI.

>Critical Congenital Heart Disease (CCHD) Screening
SCD released a policy stating that an in-patient CCHD Screening Provider shall be any general acute care hospital with licensed perinatal services, any intermediate, community and regional-level NICUs. NICUs are encouraged to develop policies to screen admitted neonates whose clinical course and care would be unlikely to detect CCHD before discharge.//2015//

>Pediatric Critical Care
CMS has structured a system of 21 CCS-approved pediatric intensive care units (PICUs) to assure that infants, children and adolescents have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS sets standards for all CCS- approved PICUs and periodically conducts PICU site visits to help ensure standards are followed. Included in the standards is a requirement to submit annual morbidity/mortality data to CCS. /2012/There are 22 PICUs; Pediatric Risk of Mortality III data are collected.//2012//

CMS and the University of California, Davis conducted a survey of PICU medical directors to assess the infrastructure for Pediatric Critical Care (PCC) quality care and the need for statewide benchmarking standards to direct QI efforts. CMS will focus on collaboration with PICU leadership in developing a statewide data collection and reporting system for QI purposes. /2012/Work is progressing on the comprehensive severity-adjusted PICU database and finalizing standards for Community Level PICUs.//2012//

/2013/In February 2012, there were 23 CCS-approved PICUs. Annual PICU reports are stratified by PRISM III scores or data through the Virtual Performance System (VPS) which exports data into the Pediatric Intensive Care Unit Evaluation (PICUEs)-PRISM III program. An Institutional and Comparative Report is submitted by PICUs. A second level PICU, designated as "Community PICU" has been developed and the first such unit approved. A PICU Regional Cooperative Agreement (RCA is under development.//2013// /2014//In 2013, two CCS Community PICUs were approved, while the RCA is being developed. The VPS California PICU database was developed to be the standard for all PICUs in California. This dataset will be representative of nearly all CSHCN in California.//2014// **/2015/ PICUs increased to 25. The PICU Database is required for all 25 PICU data gathering and reporting.//2015//**

>Pediatric Palliative Care
CMS submitted a 1915(c) waiver to the Centers for Medicare and Medicaid Services which was approved December 2008. Many stakeholders across California and in other states participated in the development of the waiver program. The program, which began to enroll children in January 2010, allows Medi-Cal clients to receive hospice-like services at home while concurrently receiving curative treatments. The program partners with hospice and home health agencies to provide a range of services to improve the quality of life for eligible children and their families including care coordination, family training, expressive therapies, respite care and bereavement counseling for caregivers. The initial three year program started in five counties: Alameda, Monterey, Santa Cruz, Santa Clara, and San Diego, and will expand to 13 counties by the third year. /2012/A request for amendment was submitted to CMS and approved to add the service: ‘pain and symptom management' (by hospice providers) in October 2010. Year two has started in Marin, Orange, SF, and Sonoma counties and is projected to expand to Fresno and LA counties this fall; these (including the first 5) are the targeted 11 counties.//2012//

/2013/The waiver was originally approved April 2009 through March 2012 for 11 of the original 13 counties participating. Medical eligibility criteria were expanded in August 2011 to include any child with a life-threatening or life-limiting CCS-eligible condition with anticipation of 30 inpatient days in the next year, who would benefit from the supportive palliative services offered by Partners for Children (PFC). The five year waiver renewal application has been

submitted.//2013// /2014/The Pediatric Palliative Care Waiver (PPCW) was renewed effective through March 2017 with UCLA conducting the program evaluation. Preliminary results show high levels of program satisfaction and significant program savings. As of December, 2012, there were 84 children enrolled in the program in nine counties, served by one of ten participating agencies.//2014// **/2015/ The PFC PPCW enrolled 85 clients. //2015//**

>Maternal Health
Maternal mortality doubled in California since 1998 to 16.9 deaths per 100,000 live births in 2006, well above the Healthy People 2010 benchmark. African-American women were roughly four times more likely to die from pregnancy-related causes with 46.1 deaths per 100,000 live births compared to 12.9 for Hispanic women, 12.4 for White women and 9.3 for Asian women. /2012/In 2008, maternal mortality dropped slightly. However, the disparity ratio for African -American mothers continued to rise.//2012// Subsequently, MCAH has supported diverse efforts to identify and address factors that appear to be contributing to increasing rates of maternal morbidity and mortality in California under the "Safe Motherhood" initiative.

First, MCAH gathers and manages statewide and local data needed to analyze factors related to poor birth outcomes and perinatal morbidity and mortality. MCAH conducts the PAMR which is the first statewide fatality review of maternal deaths. Pregnancy-related deaths from 2002 and 2003 have been reviewed and a report on findings is in development. /2012/The California Pregnancy-Associated Mortality Review: Report on cases reviewed from 2002-2003 was released in April 2011 which describes the methods, the key findings, and recommendations from the Committee. Findings have informed MCAH strategies for addressing the rise in maternal mortality. //2012//The Maternal Quality Indicator Work Group (MQI) trends maternal morbidity data and tests methods for monitoring national obstetric quality measures in California. /2012/ MQI has found significant change in maternal morbidity with increased rates of diabetes, maternal hypertension, and asthma.//2012// //2014/MQI created a composite indicator and compared ways to track elective delivery.//2014// **/2015/ MQI published the results of the maternal morbidity analysis in the American Journal of Public Health. MQI composed and submitted manuscripts for the comparative methodology manuscript on tracking elective deliveries in the Journal of Obstetric, Gynecologic and Neonatal Nursing and the Composite Childbirth Morbidity Indicators to the American Journal of Obstetrics and Gynecology. A draft of the statewide Maternal Health Report is in progress and data are being obtained to quantify the cost of maternal morbidity among Medi-Cal patients. //2015//**

Secondly, MCAH promotes creation of regionalized collaborative networks of care and ensure that patients access care appropriate to their level of risk. RPPC is a statewide regional network that provides consultation to all delivery hospitals and uses current statewide and hospital- specific outcomes data to implement strategies to improve risk-appropriate care for mothers and their babies and collaborates with perinatalogists for high-risk mothers and their infants. /2012/RPPC works with obstetric hospitals to incorporate two obstetric care toolkits; "Improving the Health Response to Obstetrical Hemorrhage" and "Elimination of Non-Medically Indicated Deliveries prior to 39 Weeks Gestation."//2012// **/2015/ The elective delivery toolkit has been implemented nationally and has been determined to be responsible for a substantial decline in elective delivery in six states where it has been implemented. //2015//** The California Perinatal Transport System (CPeTS) facilitates transport of mothers with high-risk conditions and

critically ill infants to regional intensive care units and collects transport data for regional planning and outcome analysis. MCAH also provides support for local programs to improve maternal health through maternity care improvement projects (Local Assistance for Maternal Health). Currently, San Bernardino County is providing leadership to reduce non-medically indicated labor induction with anticipated health benefits to mother and infant. L.A. County is leading a collaborative effort to improve hospital response to obstetrical hemorrhage, a leading cause of maternal morbidity and mortality./2012/The projects in San Bernardino and L.A. county will close at the end of June 2011 and two more counties have been selected to lead county wide efforts in a maternity care quality improvement project.//2012// /2013/Several LHJs are promoting preconception health.//2013// /2014/Due to funding cuts, the Local Assistance for Maternal Health (LAMH) project was reduced to only providing technical assistance through the RPPC program.//2014//

Thirdly, MCAH has developed a Maternal Health Framework (MHF) to guide program development, including improvements for current programs and opportunities to create new programs. The MHF considers social and ecological contributing factors to maternal health in three phases of the life course: prior to, during, and following pregnancy to restore a mother to health should a health complication arise during pregnancy. /2012/The MHF is being shared with all MCAH LHJs and external stakeholders as an example of an application of life course theory to real world public health policy and program planning.//2012//

For Phase I, the Preconception Health programs (described elsewhere) are focusing on maximizing health of women and girls of reproductive age before they get pregnant. Some programs target pregnant women with the goal of maximizing health during pregnancy.

For Phase II, the BIH program addresses health disparities for African-American mothers and children by facilitating access to prenatal care and providing health education and social support services to mothers. CPSP provides enhanced prenatal services to meet nutrition, psychosocial, and health education needs of clients. AFLP provides case management and education to pregnant and parenting adolescents to promote healthy pregnancy outcomes, effective parenting, and socioeconomic independence. OFP provides comprehensive education, family planning services, contraception, and reproductive health services with the goal of reducing unintended pregnancies and optimizing maternal health prior to pregnancy.

Finally, in Phase III, MCAH provides programs and services to address common complications of pregnancy. CDAPP recruits, educates and provides consultation and technical assistance to providers who deliver comprehensive health services for high-risk pregnant women with pre-existing diabetes or women who develop diabetes while pregnant. CMQCC has developed two QI toolkits: one to reduce morbidity of obstetrical hemorrhage, a common complication of pregnancy and one to reduce elective inductions of labor prior to 39 weeks gestation which appears to be associated with higher rates of cesarean delivery./2013/The toolkit//2013// /2014/"Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age"//2014// /2013/ to reduce elective inductions prior to 39 weeks gestation was licensed to the MOD for national dissemination. It will be translated into Spanish and distributed throughout Mexico based on an agreement with a Mexican national perinatal treatment center and the California Office of Binational Border Health.//2013// /2014/It includes elimination of elective inductions and elective

C-sections before 39 weeks gestation and was relicensed in 2013. The Spanish translation of the OB Hemorrhage Toolkit has been delayed.//2014// /2013/A third toolkit to improve the quality of care for preeclampsia is now in development.//2013// /2014/The toolkit to Improve the Health Care Response to Preeclampsia was released in April 2013.//2014//

WIC contributes to optimizing health outcomes throughout all three phases by linking families to local community and public health services and by providing lactation support, nutrition education, and nutritious food to low income pregnant women, new mothers and children.

/2015/>Transition

CCS adjudicates the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Service requests for skilled nursing services, Private Duty Nursing (PDN) and Pediatric Day Health Care (PDHC) services which are supplemental nursing services under the EPSDT benefit.

DHCS has implemented the EPSDT Age-Out Program to assist young adults who are currently receiving PDN and/or PDHC services and who will age out of the EPSDT service category when they reach their 21st birthday. SCD will identify these young adults at age 18 to develop an appropriate care and resource plan. //2015//

>Data and Surveillance
In 2010, MCAH began collaborating with WIC on public health research projects. The goal of the first project is to create data linkages between WIC program data, the Birth Statistical Master File, and MCAH program data in order to identify areas in California where there is a need for WIC services and opportunities to better target WIC services to MCAH populations, and to evaluate outcomes associated with the receipt of WIC services. Geographic information systems (GIS) and 21 hotspot maps will be used to examine results at local levels. /2012/Analyses were completed for linked 2008 data during the past year. Choropleth maps and hot-spot analyses were completed for specific counties and used by WIC to target resources in a funding announcement. Choropleth maps were then generated and disseminated to other WIC program areas for local planning and outreach. Data for 2009 were linked and will get analyzed in 2011 for similar resource allocation and planning purposes. MCAH also provided training and TA to State WIC staff as well as local WIC providers and agencies on how to interpret and use choropleth maps.//2012// /2013/In 2012, WIC program data were linked to the 2010 birth file. MCAH has begun to develop maps using the 2010 data, and a detailed report on WIC participation around the time of pregnancy.//2013// /2014/A detailed report was provided to WIC on 2010 WIC participation around the time of pregnancy. In 2013, WIC program data were linked to the 2011 birth file. MCAH has also started to examine the association between WIC and MCAH outcomes, such as pre-term birth.//2014// **/2015/ WIC program data will be linked with the 2012 birth file to examine WIC impact on birth outcomes.//2015//**

Second, California's Maternal and Infant Health Assessment (MIHA) Survey will be expanded in 2010. /2012/MIHA achieved a high response rate with the 2010 expanded sample, assuring adequate sample size for the proposed state and select county-level analyses of income-eligible women who are not enrolled in WIC. In 2010, women were asked their reasons for not being on

WIC. These preliminary results were shared with WIC. The final 2010 data set will be available in July 2011 and MCAH and WIC are working to identify priority analyses and applied uses of these data. //2012// /2013/County-level data tables and charts were published.//2013// /2014/Updated tables, maps, charts and reports using 2011 data will be posted online. The sample design has been revised to allow county-level estimates for the 35 counties with the most births.//2014// **/2015/ MIHA 2011 data tables, maps, charts and reports were disseminated including statewide snapshots of key MCAH indicators stratified by maternal race/ethnicity, income, age, education, and prenatal health insurance. The MIHA website has an easy-to-use searchable format. Unmet need for WIC services and reasons for not enrolling in WIC during pregnancy was assessed; an update was provided to WIC and release of a summary report is planned. MCAH provided technical assistance to DHCS and to the CDPH Office of Health Equity to assess several indicators of women's health, including disparities in breastfeeding outcomes, barriers to accessing oral health care among Medi-Cal recipients, and use of MIHA data.//2015//**

Over the past year, MCAH collaborated with CDC to develop seven proposed Healthy People 2020 measures, which will combine data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and MIHA. The combined estimates will allow tracking of key MCAH indicators, including infant sleep position, substance use and weight gain during pregnancy, postpartum smoking, and preconception/interconception care, many of which are otherwise unavailable from other data sources, and will represent approximately 85% of all births in the United States.

/2012/Six PRAMS-MIHA Healthy People 2020 (HP 2020) measures have been accepted as part of the Maternal, Infant, and Child Health topic area to provide baseline data for each HP 2020 objective. Additionally, MCAH collaborated with researchers at UCSF and CDC to submit an abstract to the 3rd National Preconception Health Conference in June 2011, highlighting the new HP 2020 objectives related to preconception/interconception health, current baseline estimates and targets for 2020, and ways that states can use PRAMS-MIHA data to monitor and inform efforts to achieve HP 2020 targets.//2012//

/2014/ In 2013, MCAH collaborated with CDC and UCSF on a Morbidity and Mortality Weekly Reports that used combined MIHA-PRAMS data to estimate how many women were eligible but not enrolled in WIC during pregnancy across 27 states and New York City. Out of all eligible women in California, 83.3% participated in WIC, the highest coverage rate in any state examined. Characteristics of WIC participants and eligible non- participants were also presented.//2014//

/2012/Since 2004, the Office of Vital Records and MCAH have collaborated to plan Birth Data Quality Workshops across California annually. Joint meetings target area hospitals with missing data and RPPC assist with presentations to birth clerks who collect birth data to better understand the items on the birth certificate, definitions of medical terms listed, and how the data helps to improve care for women and their infants. Local and state birth registrars, county MCAH Directors, local hospital administration, perinatal nursing staff, medical records and birth data collection staff are brought together, and hospitals are recognized for improvement and high achievement. In 2010, more than 530 participants attended a workshop. /2013/ 2012 is the 8th year for these workshops to improve birth data quality.//2013// /2014/ Eight workshops to improve birth data quality are scheduled for 2013.//2014// **/2015/ Birth data quality workshops will**

continue annually. //2015//

MCAH is making a concerted effort to increase surveillance capacity with GIS through use of enhanced address standardization and geocoding techniques; complex spatial analyses; automated map development with use of the Python coding language; and map building and sharing through interactive online maps. Thematic maps, spider diagrams, and statistically based hot-spot analyses of data from multiple sources (MCAH, WIC, Vital Statistics, the American Community Survey and others) have been used to locate regions at the state, county and local level in need of enhanced public health services. Hot-spot analyses were conducted to locate clusters of women in need of WIC services, or could benefit from home visiting program services.

Specialized spider diagram maps were developed to analyze geospatial associations between place of residence of mothers with very low birth weight (VLBW) infants, their delivery hospital and nearest NICU have illustrated the role that distance can play in access to appropriate care for VLBW infants.

/2015/ MCAH increased capacity for analyzing area-based measures of poverty and program participation from the American Community Survey to identify areas in need of MCAH services and targeted outreach efforts.//2015//

MCAH LHJ data books, used for local surveillance and needs assessment activities, are being revised by the Family Health Outcomes Project (FHOP) to enhance local surveillance. New indicators will be added to align with the new state priorities, State Performance Measures, and social determinants of health. Data books will be updated each year to support regular community-level monitoring, as is required by the new LHJ scopes of work.

/2014/With the support of RPPC,//2014//MCAH disseminates breastfeeding initiation rates annually to all maternity hospitals and provides them with TA to implement evidence-based policies and practices that support breastfeeding. The California WIC Association (CWA) has used these data to publish an annual report that ranks hospitals based on breastfeeding rates, generating media attention. California breastfeeding data are available at: http://cdph.ca.gov/breastfeedingdata.

/2013/MCAH continues to post hospital breastfeeding initiation data. These data were used by the CWA to publish their reports.

CCS performance measure data is reported annually by counties. For the Medical Home performance measure, 83% of CCS clients have medical homes, based on county reports of clients with Medical home, which range from 42% to 99%. **/2015//A state CCS work group updated CCS performance measures including county compliance with designating a primary care medical home physician or nurse practitioner provider; timeliness of eligibility determination; referral to appropriate CCS-approved outpatient Special Care Center (SCC)/provider; evidence of interdisciplinary SCC team visit; CCS and/or Medical Therapy Program transition planning; and family participation.//2015//**

>California's Primary and Secondary Teen Pregnancy Prevention Initiatives

Incorporation of teen pregnancy prevention programs into MCAH affords an opportunity for coordinated service delivery across primary and secondary teen pregnancy prevention efforts.//2013//. /2014/Two cross-cutting areas of focus include positive youth development and healthy relationships.//2014// **/2015/MCAH convened its first adolescent sexual health annual meeting in 2013.//2015//**

>AFLP PYD
/2012/In September 2010, MCAH received notification of a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers award from the U.S. Department of Health and Human Services (HHS), Office of Adolescent Health. MCAH received $2 million per year for 3 years, beginning 2010-2011. /2014/MCAH re-applied for funding for four years, beginning 2013-2014. //2014// MCAH seeks to improve and increase capacity of the pregnant and parenting services currently offered to eligible youth served through its Adolescent Family Life Program and the California School-Age Families Education Program (Cal-SAFE). The intent is to maximize use of limited resources through the AFLP provision of case management and support services and the Cal-SAFE provision of child and developmental services to support AFLP client school completion.//2012// /2013/MCAH awarded 11 local sites for piloting the new positive youth development case management intervention with integrated life planning to promote reproductive life planning and build youth resiliency.

/2013/>California Personal Responsibility Education Program (CA PREP)
PREP educates adolescents on abstinence and contraception to prevent pregnancy and sexually transmitted infections (STIs), through evidence-based program models and adulthood preparation subjects. /2014/Twenty-one local sub-awardees began activities in July 2012.//2014//

>Information and Education (I&E)
I&E provides adolescents with pregnancy and STI prevention information and linkages to health care. Funded through state general funds and matching Title XIX funds, the most recent request for application (RFA) for this program was released in 2010, and made funding available from Summer 2012 to Fall 2016.//2013//

> Home Visiting Program
The Maternal, Infant and Early Childhood Home Visiting Program was established on March 23, 2010 by the ACA of 2010, which amended Title V of the Social Security Act by adding Section 511. CDPH is designated as the single State entity to oversee and administer home visiting funds on behalf of California. To receive funding from HRSA and the Administration of Children and Families (ACF), MCAH began working in partnership with DSS, ADP, the California Head Start State Collaboration Office (CHSSCO) of CDE, and local stakeholders from each of California's 61 LHJs in order to develop California's Home Visiting Program application (submission, July 9, 2010), Needs Assessment (submission September 20, 2010), and Updated State Plan (submission June 9, 2011/3)./2013/MCAH was awarded the Expansion Grant to increase the number of communities served. This effort targets particularly high risk and difficult to enroll populations and evaluates individual, program and community factors affecting enrollment and retention. MCAH anticipates implementation of home visiting programs by mid- year 2012. /2014/Client enrollment began in 2012.//2014//

Two evidence-based models, Nurse-Family Partnership (NFP) and Healthy Families America, were selected to meet the needs of the 22 funded communities identified as "at-risk" through a formal Needs Assessment, a geospatial hot-spot analysis using quantitative data, and qualitative information from local MCAH Directors.

>Health Communications and Public Health Successes
MCAH continues its strong partnership with key cohorts including local MCAH programs. MCAH helped develop news releases on teen births and infant mortality. MCAH developed fact sheets on multiple MCAH-related health issues.//2013// /2014/ Since April 2014, MCAH and DHCS have been meeting monthly to improve information exchange between the programs.//2014// **/2015/ MCAH developed a news release on infant mortality.//2015//**

>Strategic Map
/2013/CDPH developed, and will implement the Strategic Map, a graphic representation of CDPH's strategy. MCAH provided input in its development and will participate in CDPH strategic priorities and objectives.//2013// /2014/In Winter 2013, the Office of Quality Performance and Accreditation was created to provide leadership and coordinate department initiatives that seek to improve the quality and performance of programs and processes within CDPH, including public health accreditation.//2014//

/2015/ CDPH's Strategic Map implementation is focused on activities, interventions and tactics identified within the six priority objectives on a department-wide basis and at the program level. MCAH is the lead on reducing the infant mortality rate ratio between Medi-Cal vs. non-Medi-Cal covered births.

CDPH submitted documentation for public health accreditation in February 2014 to the Public Health Accreditation Board.//2015//

An attachment is included in this section. IIIA – Overview

B. Agency Capacity

California has a statewide system of programs and services that provides comprehensive, community-based, coordinated, culturally competent, family-centered care. For example, Special Care Centers (SCCs) and hospitals that apply to become CCS-approved must meet specific criteria for family-centered care (FCC). FCC is assessed by the CMS Branch as part of the ongoing review process of CCS-approved SCCs and hospitals. Local CCS programs facilitate FCC by assisting families to access authorized services, such as pediatric specialty and subspecialty care, and by providing reimbursement for travel expenses, meals, and motel rooms during extended hospital stays.

/2014/Reference to Children's Medical Services and/or CMS Branch is gradually being phased out and replaced by Systems of Care Division (SCD).//2014//

MCAH and CMS programs provide direct services, enabling services, population-based services and/or infrastructure-building services. A table is attached as a guide to identify the lead agencies with which these programs are affiliated, the primary population these programs target; pregnant women; mothers and infants; children, adolescents, and CSCHN) and the availability of the program at the local or community level. These programs were created or permitted by statute and include the following:

>Adolescent Family Life Program (AFLP)

AFLP aims to promote healthy development of adolescents and their children, healthy lifestyle decisions, including immunization and pregnancy prevention and continuation of adolescents' education. It uses a case management model to address the social, medical, educational, and economic consequences of adolescent pregnancy, repeat pregnancy and parenting on the adolescent, her child, family, and society. It also links clients to mental health, drug and alcohol treatment, foster youth, family planning and dental care services and direct services available through Medi-Cal and Temporary Assistance for Needy Families (TANF) or Cal Works as it is known in California. AFLP targets services to pregnant and parenting teens and is providing services to approximately 6000 adolescents in 38 /2014/33//2014// programs throughout the State. In many counties, AFLP is the only case management program available for pregnant and parenting teens. /2012/ The caseload for 2010 was 8,902 clients in 37 programs./2012// /2013/ MCAH awarded 11 local agencies to increase program capacity and professional development in the area of positive youth development.//2013/ **/2015/MCAH was re-awarded a second Pregnancy Assistance Grant to fund 17 agencies implementing the Positive Youth Development initiative.//2015//**

>Black Infant Health (BIH)

BIH which has the goal of reducing African American infant mortality in California uses case management and group interventions to support African American women in their pregnancies and improve birth outcomes. The BIH program is currently serving approximately 3000 women in 16 programs in the State. /2012/BIH revised services to include a client-centered, strength-based group intervention with case management. //2012//

>California Birth Defects Monitoring Program (CBDMP)

CBDMP collects and analyzes data to identify opportunities for preventing birth defects and improving the health of babies. The 2006 /2014/2009//2014// **/2015/2010 //2015//** birth year information was recently linked to vital statistics live birth and fetal death information, creating a database of more than 129,000 /2014/135,323//2014// pregnancies affected with birth defects from a base population of 6.25 million births. Birth year 2007 /2014/2010//2014// linkage will be completed soon. /2013/Birth year information is linked to vital statistics data for eight counties. The CBDMP Registry has data for more than 140,000//2013// /2014/144,650//2014// **/2015/147,379//2015//** babies with birth defects since 1983.//2013//

>California Children's Services (CCS) Program

CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae.

The program authorizes medical and dental services for CCS-eligible conditions, establishes standards for providers, hospitals, and SCCs for the delivery of care, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions. Thirty-one "independent" counties fully administer their own CCS programs, and 27 "dependent" counties share administrative and case management activities with CMS Branch Regional Offices. Social Security Income (SSI) beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program. /2012/The CCS caseload for FFY 2009 is 179,306 of which 76.1% are in Medi-Cal; 14.3% in HF, and 9.6% in state only CCS.//2012// /2013/There were 246,301 clients in the CCS Program in SFY 10-11, /2014/ and 222,032 in SFY 11-12//2014// based on the CMS Net system.//2013//

CCS has a regional affiliation system with 114 CCS-approved NICUs. NICUs providing basic level intensive care services are required to enter in to a Regional Cooperation Agreement (RCA) with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. CCS approves the designated level of patient care (Intermediate, Community and Regional) provided in each NICU, and verifies that the RCA is in place. Starting with 2004 data, all CCS NICUs are required to submit their CCS data through CPQCC**.**

>California Diabetes and Pregnancy Program (CDAPP)

CDAPP promotes optimal management of diabetes in at-risk women, before, during and after pregnancy. Regional teams of dietitians, nurses, behavioral specialists and diabetic educators provide training and technical assistance to promote quality care provided by local Sweet Success providers and to recruit and train new Sweet Success providers in areas of need. /2013/CDAPP funding for regional services was eliminated; however, a resource and training Center will be maintained//2013// /2014/to provide webinar trainings and resources to CDAPP Sweet Success Affiliates.//2014//

>California Early Childhood Comprehensive Systems (ECCS)

ECCS promotes universal and standardized social, emotional, and developmental screening. ECCS collaborative efforts provide CHDP with guidance on validated and standardized developmental/social-emotional health screening tools for earlier identification of children with developmental delays. The revised guidelines were an important collaboration between CHDP and the MCAH led team of the national Assuring Better Child Health and Development (ABCD) Screening Academy Project. The work to enhance California's capacity to promote and deliver effective and well-coordinated health, developmental and early mental health screenings for young children, ages 0-5, continues through the Statewide Screening Collaborative (SSC), which served as the stakeholders in the ABCD project.

/2014/Plans were developed to implement Help Me Grow whose core components complement the developmental screening activities of the California Home Visiting Program and California's Race-to-the-Top Early Learning Challenge.//2014//

ECCS is partnering with Alameda County to develop early childhood programs of care for children 0 to 8 years of age called the California Project Launch. /2012/Project Launch's goal is to show the feasibility and impact of recommended policy changes to establish and maintain a developmental continuum that prepares children to learn. //2012// /2014/Systems change resulted in introducing evidence-based practices; improved social-emotional services; new partnerships; a shift toward a more comprehensive early childhood view (ages 0-8); promoting improved screening tools, curricula, and referral protocols; and working toward a common framework for providing child and family services.//2014//

/2013/California Home Visiting Program staff has recently convened the State Interagency Team (SIT) Workgroup, whose stakeholder members include ECCS and California Project LAUNCH (CPL). SIT will work to improve the quality, efficiency, and effectiveness of home visiting through interagency collaboration.//2013// **/2015/ ECCS focused on strengthening its partnerships. California will develop a mutually designed cross-agency agenda for change.. //2015//**

>Child Health and Disability Prevention (CHDP) Program

CMS administers the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, called the CHDP Program. CHDP provides preventive services and referral to diagnostic and treatment services for Medi-Cal participants up to age 21. Uninsured children up to age 19 in households at or below 200% of the FPL can pre-enroll in Medi-Cal through the Gateway process.

CHDP provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutrition assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

/2015/In 2013, children were transitioned from Medi-Cal fee-for-service to Medi-Cal Managed Care health plans (MCMC). MCMC expansion increased the number of CHDP beneficiaries receiving health assessments. ACA implementation, and adoption of the Modified Adjusted Gross Income guidelines increased the number of eligible children and families for full scope Medi-Cal services. CHDP continues to provide, care coordination, referral support, and assistance with scheduling and transportation to non-managed care enrolled children, foster care and uninsured children.//2015//

>Comprehensive Perinatal Services Program (CPSP)

CPSP provides comprehensive perinatal care including obstetrical, nutrition, health education, and psychosocial services from qualified providers to Medi-Cal eligible women. There are 1566 active CPSP providers in California /2012/(1592 for 2010)//2012//. MCAH develops standards

and policies; provides TA and consultation to the local perinatal services coordinators; and maintains an ongoing program of training for all CPSP practitioners throughout the state. Local MCAH staff /2012/monitor service delivery, recruit new providers, and//2012//offer TA and consultation to potential and approved providers in the implementation of CPSP program standards.

>Fetal Infant Mortality Review Program (FIMR)

Sixteen local LHJs have FIMR Programs that enable them to identify and address contributing factors to fetal and infant mortality. A Case Review Team examines selected fetal and infant death cases, /2013/ conducts maternal interviews,//2013// identifies factors associated with these deaths, and determines if these factors represent systems problems. /2014/A Case Review Team examines fetal and infant death cases, and identifies factors, including systems issues associated with these deaths.//2014// Recommendations from the Case Review Team are presented to a Community Action Team that develops and implements interventions that lead to positive changes. /2013/MCAH is building an aggregated database with data reporting from all 16 jurisdictions//2013//.

>Genetically Handicapped Persons Program (GHPP)

GHPP provides case management and funding for medically necessary services to people with certain genetic conditions. Most GHPP clients are adults, but 4.6 percent are children under 21 years. The GHPP serves eligible children of higher family incomes who are ineligible for the CCS program.

GHPP client enrollment is stable, with 1750 clients for 2008-2009. /2013/GHPP client enrollment for 2010-2011 was 1537.//2013//

> Hearing Conservation Program (HCP)

HCP helps to identify hearing loss in preschoolers to 21 years of age in Public Schools. All school districts are required to submit to CMS an annual report of hearing testing. /2013/For 2009,10,780 school districts reported their hearing screening results and 1.9 million students were screened.//2013//

>Health Care Program for Children in Foster Care (HCPCFC)

HCPCFC is a public health nursing program /2013/administered by the local CHDP Program, is //2013//located in county child welfare service agencies and probation departments to provide public health nurse expertise in meeting the medical, dental, mental and developmental needs of children and youth in foster care. /2014/As of May 2012, the foster care children caseload was 57,459.//2014// **/2015/Funds for HCPCFC were redirected to county welfare agencies but an alternative funding structure is maintained until transition occurs in FY 2015-16. //2015//**

>High Risk Infant Follow-up (HRIF)

Infants discharged from CCS-approved NICUs are followed in NICU HRIF clinics. Three multidisciplinary outpatient visits are authorized by CCS up to age three to identify problems, provide and complete referrals, and monitor outcomes.

The HRIF program continues to provide three multidisciplinary outpatient visits /2014/ and additional visits as determined medically necessary//2014// to identify problems, institute referrals, and monitor outcomes. The QCI developed a web-based reporting system to collect HRIF data for quality improvement activities. Statewide trainings were provided to all NICU and HRIF Program staff before implementation and a follow-up training was held in February 2010. /2014/Statewide data trainings were held. By March 2013, 67 of 69 HRIF programs are reporting online.//2014//

/2015/The State Systems Development Initiative grant supports a web-based HRIF Data Reporting System. HRIF QCI developed a provider resource directory to motivate communication between the NICU and HRIF Programs. The HRIF QCI data system update reported >33,100 total referrals/registrations for birth years 2009-2013.//2015//

/2012/

>California Home Visiting Program (CHVP)

CHVP aims to improve service coordination for at-risk communities to promote improvements in maternal and infant health, school readiness, reduction of child maltreatment, improved community referral systems, and reductions in crime and domestic violence.//2012// /2013/The focus will be on the implementation of two evidence-based home visiting models: Nurse Family Partnership (NFP) and HF America,//2013// /**2015/early childhood system integration and continuous QI //2015//**

>Human Stem Cell Research Program (HSCR)

HSCR develops comprehensive guidelines to address the ethical, legal, and social aspects of stem cell research and ensure the systematic monitoring and reporting of HSCR activity that is not fully funded by Proposition 71 money granted through the California Institute for Regenerative Medicine. A diverse group of 13 national and international specialists serve on a HSCR Advisory Committee to advise CDPH on statewide guidelines for HSCR.

/2014/

>Information & Education (I&E) Program

The I&E Program funds local agencies to implement sexual and reproductive health education programs that equip teens at high risk for pregnancy with the knowledge, and skills in partner communication, sexual negotiation and refusal skills to make responsible decisions regarding risky sexual behaviors, and to access reproductive health services.//2014//

>Local Health Jurisdiction (LHJ) Maternal Child and Adolescent Health Programs (LHDMP)

61 LHJs receive Title V allocations that support local infrastructure, including staff, to conduct culturally sensitive collaborative and outreach activities to improve services for women and children, refer them to needed care, and address state and local priorities for improving the health of the MCAH population.

>MCAH Toll-free Hotline

MCAH staff responds to calls and refer callers to local MCAH programs. LHJs also have local toll-free numbers that provide information and referrals to clients. Local MCAH contact information is made available online.

>Medical Therapy Program (MTP)

MTP provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. MTP conducts multidisciplinary team conferences to support case management and care coordination. The number of clients enrolled in the MTP has shown a slight declining trend over the past 5 years of 7% and is currently 24,777 /2012/in 2010 and 24,433 for 2011.//2012// /2014/ Client enrollment is below 1999 levels.//2014// **/2015/ The program has implemented use of outcome measure tools to assist therapists to determine effectiveness of therapy services./2015//**

>Newborn Hearing Screening Program (NHSP)

NHSP helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills. In California, 243 hospitals are certified to participate in the NHSP as of December 2009. /2013/Five hospitals were pending certification and 253 hospitals certified as Inpatient Infant Hearing Screening Providers.//2013// /2014/All hospitals with licensed perinatal services are certified and participating in the NHSP.//2014//

>Pediatric Palliative Care Waiver Program (PPCWP)

This program allows for the provision of expanded hospice type services and curative care concurrently. This program is designed to improve the quality of life for children with life limiting or life threatening conditions, and their family members. It is anticipated that cost neutrality will be achieved by reduced hospital stays, medical transports, and emergency room visits in addition to other costs avoided while the child is enrolled in the program. /2013/As of March 2012, there were nine active hospice or home health agency providers.//2013//

//2015//As of March 2014 three hospice agencies, three home health agencies, and one congregate living health facility participate in PPCW program.//2015//

/2014/

>California Personal Responsibility Education Program (CA PREP)

CA PREP educates high-risk adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, through replication of evidence-based programs to delay sexual activity, increase contraceptive use or reduce pregnancy. CA PREP also implements activities to prepare young people for adulthood and are also referred to family planning related health care services.//2014//

>Regional Perinatal Programs of California (RPPC)

RPPC promote access to risk-appropriate perinatal care to pregnant women and their infants through regional QI activities. RPPC facilitate local perinatal advisory councils to provide regional planning, coordination, and recommendations to assure appropriate levels of care. In addition, the local perinatal advisory councils perform hospital surveys and perinatal assessments of regional and statewide significance; develop communication networks locally; disseminate educational materials and produce a statewide newsletter; provide resource directories, referral services, and hospital linkages to the Northern and Southern CPeTS; and assist hospitals with QI activities, data collection protocols, and quality assurance policies and procedures. /2013/ Production of a newsletter was terminated.//2013// /2014/ A mid-year report including updates to steps toward reduction of early elective deliveries <39 weeks by hospitals was implemented.//2014//

CPeTS maintains a web-based bed availability list, locate beds for high-risk mothers and infants and provide transport assistance, transport data reports, and perinatal transport QI activities, including emergency triage and transport in the event of a disaster. Maternity hospitals can obtain information 24 hours a day, 7 days a week to facilitate transfers. /2014/ All CCS-approved NICUs are included. QI activities are focused on in-transit operational and therapeutic management issues.//2014//

>Sudden Infant Death Syndrome (SIDS) Program

SIDS is funded in all 61 LHJs to provide support to families that experience a SIDS death, conduct prevention activities, and enable staff to attend annual training. The SIDS Program provides statewide technical assistance and support to healthcare and public safety personnel and parents including education about SIDS, grief counseling, and information on prevention to reduce the risk of SIDS.//2014//

>Technical Assistance

MCAH places high priority on providing stakeholders and partners with quality assistance where necessary to improve MCAH program performance. The following programs were created to address the developmental assistance needs in the state:

>Breastfeeding Technical Assistance Program

This program promotes and supports efforts to make breastfeeding the infant feeding norm. Its website (http://www.cdph.ca.gov/programs/breastfeeding/Pages/default.aspx) contains targeted breastfeeding information for families and providers. It has piloted BBC to assist hospitals to

improve their exclusive breastfeeding rates and collaborated with Medi-Cal, WIC and the CA Breastfeeding Coalition to improve hospital support for breastfeeding.

/2013/

> Nutrition and Physical Activity Technical Assistance Initiative

This integrates healthy eating and physical activity promotion within MCAH and its local programs. Strategies include providing technical assistance, development of healthcare policies, training and guidelines; supporting partners in coalition building; and using epidemiological information to design, implement, and evaluate nutrition and physical activity initiatives.//2013//

>Oral Health Technical Assistance Program

Oral Health Program provides local technical assistance and state level coordination and collaboration to address the oral health needs of pregnant women, mothers, children and adolescents, especially within low-income families, by expanding access to dental care and preventive services, and by encouraging local MCAH Programs to work in collaboration with new and existing dental and health-related programs. This year, 18 local MCAH programs have chosen oral health as a priority objective. Another 25 /2012/21//2012// local MCAH programs collaborate on various community tasks forces involving oral health issues. Further, direction has been provided by updating oral health educational components in the CPSP "Steps to Take" Guidelines, BIH prenatal and postpartum curriculums, AFLP "Infant Feeding" Guidelines and CDAPP's Sweet Success Guidelines./2012/MCAH is disseminating perinatal clinical oral health guidelines to assist providers deliver oral health services.//2012//

>Preconception Health and Healthcare

MCAH is partnering with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health practice, develop policy strategies to support preconception care, and promote preconception health messages to women of reproductive age. /2012/Reproductive life planning concepts and tools are being integrated into BIH and AFLP programs.//2012// /2013/MCAH provides preconception health training and technical assistance.//2013// /2014/MCAH partnered with the Office of Minority Health to trained support preconception peer educators in colleges and universities.//2014//

Major Collaboratives

MCAH and CMS value the input provided by its stakeholders across communities and has actively fostered collaboratives, task forces, and advisory/work groups to address MCAH and CSHCN health issues. These collaboratives, task forces, and advisory/work groups also serve to coordinate preventive and health care delivery with other services at the community level as well as with the health components of community-based systems. These include the following:

> Adolescent Sexual Health Work Group (ASHWG)

ASHWG is a collaborative of 23 organizations from CDPH, CDE and non-governmental organizations who address sexual and reproductive health needs of youth. Its vision is to create a coordinated, collaborative, and integrated system among government and non-government

organizations to promote and protect the sexual and reproductive health of youth in California. Current activities focus on core competencies for /2012/youth//2012//providers and educators, integrated data tables (available at:http://www.californiateenhealth.org/download/ASHWG_Integrated_Data_Tables.pdf) and /2014/positive//2014// youth development.

>California Perinatal Quality Care Collaborative (CPQCC)

CPQCC is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals and business groups. It develops perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. For 2010, CPQCC membership is at 128 NICUs, with all of the 114 CCS-approved NICUs as members/2012/; for 2011, there were 129 NICUs, with 115 CCS-approved NICUs as members.//2012// /2013/CPQCC includes hospitals representing over 90% of all neonates cared for in NICUs.//2013//The Perinatal Quality Improvement Panel (PQIP), is a standing subcommittee of CPQCC, that provides oversight for all quality functions of CPQCC by creating, initiating and conducting statewide quality projects and/or prospective trials; publishing and disseminating new and updated QI toolkits; analyzing the CPQCC database and designing supplemental data collection tools; and initiating and implementing research projects focused on QI. /2012/PQIP revised its charter and re-designed its structure, developing four sub-committees.//2012// /2013/The goal is to support benchmarking and performance improvement activities http://www.cpqcc.org/quality_improvement/collaborative_3_delivery_room_management_qi_collaborative_and_nicu_qi. //2013// /2014/ PQIP defines indicators and benchmarks, recommends QI objectives, provides models for performance improvement, and assists providers in a multi-step transformation of data into improved patient care.//2014//

/2015/CPQCC members include 116 CCS-approved NICUs and 132 NICUs . There are 25 NICUs participating in the PQIP-sponsored quality improvement collaborative which aims to optimize length of NICU hospital stay. //2015//

> California Maternal Quality Care Collaborative (CMQCC)

CMQCC is the statewide umbrella organization for assessing the current state of knowledge of maternal illness and complications and transforming this knowledge into targeted, evidence-based, data-driven clinical quality improvement interventions and public health strategies statewide and at the local level. CMQCC's mission is to end preventable maternal morbidity and mortality by improving the quality of care women receive during pregnancy, childbirth, and postpartum. CMQCC maintains an informative website of resources and policies for both public and private use (www.cmqcc.org) and provides educational outreach to health professionals. /2012/CMQCC convenes the Pregnancy-Associated Mortality Review (PAMR) Committee and provides TA to local maternity care quality improvement projects. CMQCC also developed and disseminated two toolkits for obstetric care providers: "Improving the Health Response to Obstetric Hemorrhage" and "Eliminating Non-Medically Indicated Deliveries Before 39 Weeks of Gestational Age".//2012// /2013/CMQCC is preparing a third toolkit to improve identification and effective therapy for preeclampsia/eclampsia and is developing a maternal data center to track maternity care quality improvement efforts.//2013// /2014/The Preeclampsia Prevention Toolkit was released and a multi-hospital collaborative was initiated. MCAH participates in an advisory

committee to develop risk appropriate maternal levels of care and the California Maternal Data Center.//2014// /**2015/ The next QI toolkit for release will address cardiovascular disease in pregnancy targeting family medicine and ER staff.//2015/**/

>Family Voices of California (FVCA)

FVCA helps CSHCN families through a coordinated network of regional, family-run FVCA Council Member agencies. FVCA continues to provide information to families and professionals on issues relating to a Medical Home, including organizing healthcare information and navigating health systems, /2014/changes in Medi-Cal, the difference between occupational therapy (OT) and physical therapy (PT) and medically related OT and PT; autism; and insurance.//2014//

FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to 1115 Waiver, CCS redesign, and the Title V Needs Assessment. FVCA has ensured that parents and community members are involved in these processes, has provided financial support to families to enable their involvement, and has facilitated providing parent and community member input through key informant interviews and focus groups. /2014/FVCA will evaluate CSHCN's timely access to appropriate care providers during the HF client transition into Medi-Cal.//2014//

/2012/

>Maternal Quality Indicator (MQI) workgroup

The MQI workgroup conducts trend analysis of maternal morbidity rates, chronic conditions that compromise maternal health//2012// /2013/ analyzes composite healthcare costs maternal morbidities//2013// /2012/and suggests strategies for monitoring quality benchmarks for obstetric hospitals//2012// **/2015/ MQI developed a composite morbidity indicator to combine reporting maternal and neonatal morbidity.//2015//**

>Prenatal Substance Use Prevention

MCAH's efforts related to perinatal substance use prevention are conducted through partnerships and collaboration. MCAH representatives participate in the California Fetal Alcohol Spectrum Disorders (FASD) Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. MCAH also participates in the State Interagency Team FASD workgroup, composed of members from the MCAH, (DSS, Department of Mental Health (DMH), CDE, Department of Developmental Services (DDS) and ADP acting as lead. The goal of the workgroup is to identify interagency and systems issues that provides potential opportunities for prevention/intervention of FASD. /2013/The FASD Workgroup gave its recommendations in May 2010.//2013//

MCAH LHJs have identified perinatal substance use prevention as a priority. They have engaged in community mobilization and capacity building, and implemented screening, assessment, and referral to treatment programs that address their particular needs.

>Preconception Health Council of CA (PHCC)

One of the key ways that MCAH partners with other entities is through PHCC which was established in 2006 by MCAH and MOD, California Chapter. In May 2009 the PHCC launched its official website: www.everywomancalifornia.org, which is supported by Title V funds. The website contains information for both consumers and providers and includes an interactive section for health professionals featuring discussion forums, opportunities for networking and resource-sharing, and an event calendar. MCAH also received a First Time Motherhood grant from HRSA/MCHB to develop a preconception health social marketing campaign reaching women at increased risk for poor pregnancy outcomes. /2013/The Interconception Care Project of California and the California Guidelines for Preconception Care were developed through the PHCC.//2013// **/2015/PHCC developed clinical guidelines for preconception care.//2015//**

>Transition Workgroup

CMS recognizes the importance of transitioning health care for CSHCN from pediatric to adult services. During site reviews of new SCCs and CCS programs, the issue of health care transition planning and age and developmentally appropriate care for CSHCN was reviewed and discussed.

CMS formed a statewide Transition Workgroup comprised of healthcare professionals, experts in transition care, former CCS clients, and family representatives who worked together on the Branch's Transition Health Care Planning Guidelines for CCS programs. The Guidelines were released in 2009, as a CCS Information Notice.

CMS collaborates with the California Health Incentives Improvement Project (CHIIP) and is funded by the Medicaid Infrastructure Grant (MIG) from the Centers for Medicare and Medicaid Services. As staffing allows, CMS will participate on the CHIIP Youth Transition Advisory Committee. /2014/ The Youth Transition Advisory Committee was defunded and terminated.//2014//

Business Partners

To further enhance current capacity to provide community based preventive and health care services, expertise in health related services through the provision of technical assistance is improved via contractual relationships with clinical and academic health experts. These include:

/2012/

> Advanced Practice Nurse Program (APN)

APN maintains accredited advanced practice nursing programs. The program goals are to increase the availability of quality reproductive health care services for childbearing women in underserved areas by preparing nurses in a program that meet state and national guidelines and recruit and enroll students.//2012// /2013/APN was eliminated effective July 2012.//2013//

>Branagh Information Group

MCAH contracted with the Branagh Information Group to develop, maintain, and provide technical assistance for LodeStar, a comprehensive software package for AFLP agencies conducting case management for pregnant and parenting teens and their children. Branagh Information Group was also contracted to develop and maintain BIH Management Information

Services (MIS), a software package for BIH agencies conducting case management. /2013/Branagh Information Group provides Help Desk support and training for the BIH MCAH MIS, a new database for BIH.//2013// **/2015/ Branagh Information Group no longer provides services to BIH agencies.//2015//**

>The California Adolescent Health Collaborative (CAHC)

MCAH has a contract with CAHC to provide adolescent health expertise, address current adolescent health concerns through technical assistance to the local MCAH programs and other partners. CAHC also supports core activities of ASHWG. /2012/ Through Internet Sexuality Information Service, CAHC reaches adolescents using digital media.//2012// /**2015/ The Internet Sexuality Information Services was suspended due to funding reallocation.//2015//**

>California State University, Sacramento (CSUS)

CSUS provides /2012/and coordinates//2012// CPSP Provider /2012/Overview and Steps To Take//2012// Training, is developing on-line provider training, and supports statewide /2012/CPSP//2012// meetings.

>Childhood Injury Prevention Program

To reduce injury-related mortality and morbidity among children and adolescents, MCAH contracts with the Center for Injury Prevention Policy and Practice (CIPP

P) at San Diego State University. CIPPP provides technical support for local MCAH programs and their partner agencies via face to face meetings, teleconferences, e-mail, a list serve, and literature reviews of the latest injury prevention research /2014/from journals and reports from more than 30 professional disciplines.//2014// **/2015/Funding to San Diego State University/Center for Injury Prevention Policy and Practice (CIPPP) was cut in 2013.//2015//**

>Family Health Outcomes Project (FHOP) at the University of California, San Francisco

FHOP provides technical assistance and training, analyzes data for LHJs, provides a current web listing of useful resources, assists in establishing guidelines, and prepares special state reports for MCAH and CMS./2012/FHOP is working with CMS on developing and implementing a family survey for use over the next five years.//2012// **/2015/SCD is working with FHOP to conduct the 2015 statewide needs assessment. //2015//**

>Health Information Solutions

With direction from MCAH, Health Information Solutions developed and maintains the Improved Perinatal Outcomes Data Reports (IPODR) website. IPODR allows users to view and download the most recent demographic and hospital data about California mothers and infants. The data are available in tables for the most recent year available, in maps aggregating the past three years, and in graphs displaying a 15-year **/2014/20-year//2014//** trend. Information is available at the state, county, and zip code levels.

/2015/
>Los Angeles Partnership for Special Needs Children (LAPSNC)

LAPSNC is a group of community providers, payers, community based organizations and parents that works with LA CCS and LA Family Resource Centers on improving the system of care for children with special health care needs in Los Angeles County.//2015//

>Perinatal Profiles at the School of Public Health, University of California at Berkeley
This project produces an annual report that provides information on sentinel indicators of perinatal quality care for all the maternity hospitals and regions in California that may reveal where efforts are needed for the purpose of continuous quality improvement. /2014/The report provides information about birth certificate data completeness and quality.//2014// **/2015/Due to funding cuts, the Perinatal Profiles Report is no longer being produced.//2015//**

/2012/
>Public Health Institute (PHI)
Together with MCAH, PHI conducts medical record abstraction and assists in the data analysis for PAMR.//2012//

>Maternal and Infant Health Assessment (MIHA) with the Center on Social Disparities in Health, University of California in San Francisco MIHA is an annual survey that collects population-based information about maternal health status, health behavior, knowledge, and experiences before, during, and shortly after pregnancy. Findings are disseminated through conference presentations, reports, and posting of survey results through the MCAH website.

/2014/
>Center for Health Policy at University of California, Los Angeles (UCLA)
The Center for Health Policy was contracted to develop cost savings estimates of early management of preeclampsia, eclampsia and obstetric hemorrhage.//2014// **/2015/The October 2013 reports [27] show that 5.6% (27,580) of 2011 CA births were complicated by gestational hypertensive disorders while 4.6% (22,730) had maternal hemorrhage complications and $106 million, respectively to treat these conditions.//2015//**

Select Statewide Programs Serving the MCAH Population

Medi-Cal and HF provide California's low-income children with access to comprehensive primary and preventive services, including dental care. Medi-Cal covers children ages 1 through 5 living in household at up to 133% of FPL, children and adolescents ages 6 to 19 at up to 100% of FPL, and young adults ages 19 to 21 at up to 86-92% of FPL. HF covers children up to age 18 who are uninsured and in households at up to 250% of FPL. Monthly premiums and co-payments for certain types of visits and prescriptions are required.

As of January 2010, there were 878,005 children enrolled in HF, an approximately 1.6% decrease from the previous year. Of those children, approximately 2.9% (25,878) are being served by CCS for their special health care needs.

Specific to infants, Medi-Cal, HF, and (AIM) provide health insurance for infants. Medi-Cal reaches infants in households below 200% of FPL. HF reaches infants in households up to 250%

of FPL; monthly premiums and co-payments are required. AIM provides state-subsidized third party insurance for infants in households at 200-300% of FPL.

State law requires MRMIB to enroll infants of AIM mothers into HF. AIM infants above 250% will be able to continue in HF up to 2 years of age before having to meet current eligibility. As of January 2010, CCS serves 418 AIM children. /2012/As of February 2011, 865,480 children were enrolled in HF. Of these, 2.6% (22,130) are served by CCS.//2012//

/2014/ State law required the transition of children enrolled in HF to Medi-Cal. HF continues to serve children that have not yet transitioned to Medi-Cal, including AIM -linked infants.//2014// **/2015/In 2013, HF no longer enrolled new applicants – see HCSI 3.//2015//**

>Rehabilitation services

Services such as physical therapy for SSI beneficiaries under the age of 16 with a CCS medically-eligible diagnosis are served by MTP. Children with mental or developmental conditions receiving SSI are served by the DMH, DDS and CDE. In FY 2009-2010, CCS received 86 referrals. Of these, five were not medically eligible for CCS and two could not be verified. CCS will continue to work with the Disability Evaluation Division to train local staff to conduct CCS medical eligibility evaluations which should result in fewer referrals to CCS. **/2015/CCS provides medical eligibility evaluation trainings. The Department of Rehabilitation (DOR) was awarded a Promoting Readiness of Minors in Supplemental Security Income grant in October 2013 to benefit families of CSCHN/YSHCN who receive Supplemental Security Income which may include CCS-enrolled CSHCN**

>Family-centered, community-based coordinated care (FCC) for CSHCN

SCCs and hospitals that treat CSHCN who wish to become CCS-approved must meet specific criteria for FCC. FCC is assessed and recommendations are made as part of the review process by the CMS Branch.

CCS facilitates FCC services for families of CSHCN. CCS allows a parent liaison position in each county CCS to enable FCC. County programs assist families to access authorized services, such as pediatric specialty and subspecialty care, and provide reimbursement for travel expenses, meals, and motel rooms during extended hospital stays. Many county CCS are terminating parent liaison contracts due to state budget cuts.

In 2009 the Children's Regional Integrated Service System (CRISS) annual FCC conference focused on mental health services for children and youth with special health care needs. The conference was co-sponsored with the University Center on Excellence in Developmental Disabilities (UCEDD), FVCA, and CMS. /2012/In 2010 CRISS FCC conference was "Working Together in Challenging Times: CCS, Families and the Community".//2012// **/2015/ CRISS brings together CCS programs, family support organizations, and pediatric providers and hospitals in a cohesive regional coalition for collaboration, planning and action.//2015//**

The CRISS National Initiative for Children's Healthcare Quality project to promote medical homes for children with epilepsy in a Sonoma County Federally Qualified Health Center (FQHC)

was completed in 2009. CRISS worked with the Sonoma County CCS program to take on responsibility for continuing to convene the project's local oversight committee, and FQHC is continuing activities to support medical homes for children with epilepsy. **/2015/This project ended but Sonoma CCS continues medical home activities with a managed care plan.//2015//**

Additionally, CRISS makes available the parent health notebook and other medical home materials on its website www.criss-ca.org. /2013/CCS is partnering with CRISS to provide local medical home projects. The Alameda Medical Home Project is implemented through provider training in medical home concepts, resources, and referral pathways with pediatric practices and clinics.//2013// **/2015/CRISS continues the FCC workgroup. FVCA and 15 FRCs participate in CRISS.. Parent health notebooks are available to family resource networks, and on the CRISS website. //2015//**

L.A. Partnership for Special Needs Children (LAPSNC), which promotes parent involvement in meetings and on committees, cosponsored an all-day conference entitled "Weathering Difficult Times: Resources for Children with Special Needs and their Families". Parents served on the planning committee for this meeting and 130 providers and parents were in attendance. /2012/LAPSNC is planning a conference in 2011 focusing on the impact of the 1115 waiver on CSHCN.//2012//

FVCA continues its active role as a significant resource for families and professionals on issues relating to a medical home, including organizing healthcare information and navigating health systems.

In 2009, FVCA created a youth council, Kids As Self Advocates (KASA), that meets once a month via conference call and face to face every other month. CCS has attended some of the KASA meetings, and KASA youth have provided input to CCS on transition issues. KASA youth have received leadership training, and FVCA provides staff time for a youth group coordinator and provides youth with stipends for participation at meetings and travel.

In addition to youth leadership training, FVCA is developing the FVCA Parent Leadership Training Curriculum to prepare families to partner in decision-making and has piloted trainings at the annual Family Resource Supports Institute.

In 2009, FVCA was a collaborative member of "Partners in Policymaking" and worked to provide leadership training to 35 self-advocates and parents of children with developmental disabilities in L.A. County. The 2010 training will be in San Bernardino County.

Over the last eight years, FVCA in collaboration with advocates across the state convened annual statewide Health Summits that have brought together families, professionals, agency representatives, advocates, insurers, health policy experts and legislators to discuss access to affordable and appropriate health care for CSHCN and to develop strategies to address the challenges families face. FVCA funds this conference through its federal MCHB grant and private sponsors, thus providing families with travel scholarships and stipends to be able to

attend. Other FVCA 2009 activities have included: Council's monthly meetings to address parent and community involvement; hosting 9 statewide webinars for families and professionals on topics such as the Family Opportunity Act, health care transition, nutrition for CSHCN and impacting legislation; and participation in the Prematurity Coalition's Summit, providing and organizing a panel on Home Based Community Care to address parent and community involvement during and after hospital stays for families with babies born prematurely.

In 2009 and 2010, FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to 1115 Waiver, CCS redesign, and the Title V Needs Assessment, ensuring that parents and community members are involved in these processes. FVCA has provided financial support to families to enable their involvement, and has facilitated parent and community member input for interviews, focus groups, and surveys. /2013/FVCA and CCS hold monthly webinars with families of CSHCN.//2013// /2014/ CCS leadership presents program updates at the annual FVCA summit.//2014//

Approaches to Culturally Competent Service Delivery

Because California is a cultural melting pot, it is paramount that both MCAH and CMS interact and provide services in a culturally, linguistically and developmentally competent manner with people of diverse backgrounds. Both MCAH and CMS value and respect the diversity of clients that our programs serve. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures. Both MCAH and CMS have mechanisms to promote culturally and linguistically competent approaches to service delivery such as:

> BIH delivers culturally competent services to address the problem of disproportionate African American maternal and infant mortality.

/2013/>CDAPP Resource and Training Center has brochures, teaching aids and a food guide in various languages.//2013//

> MCAH and CMS collect and analyze data according to race, ethnicity, age, etc. to identify disparities.

> MCAH and CMS program materials are mostly published in English and Spanish, and translated to other languages as needed.

> FIMR has posted a guide and tool on the MCAH website for assessing cultural and linguistic competence among their funded agencies.

>/2015/Telehealth
CCS Telehealth policies were clarified through stakeholder meetings and a CCS policy letter. SCD works with CSHCN stakeholders to expand Telehealth care access.//2015//

An attachment is included in this section. IIIB - Agency Capacity

Budget and Expenditures

A. Expenditures

The budget and expenditures for FFY 2011 are presented in Forms 2, 3, 4, and 5.
/2014/Expenditures and budget amounts include over $2 billion in Medicaid funds that California expends on direct care services and case management of some of the CSHCN programs.//2014//

/2013/ The reductions in federal Title V funding has resulted in programmatic adjustments to reduce expenditures in infrastructure building services which will affect the following:

MCAH Division

MCAH is reducing 6.0 positions and over $6.8 million in funding expenditure authority for FY 2012/13. Reductions to travel and general expense allocations will limit MCAH's ability to conduct mandatory on-site program reviews, provide technical assistance and respond to information requests from LHJs and MCAH stakeholders. The positions being eliminated are:

> Nurse Consultant III (Specialist) – Elimination of this position limits technical assistance capacity to support oversight and effective implementation of newly revised scope of work (SOW) for local MCAH, BIH, and AFLP programs. Nurse Consultant capacity for oversight, development, and long-delayed improvements to the Comprehensive Perinatal Services Program (CPSP) will be reduced by 25 percent. These functions are necessary to ensure CDPH/MCAH compliance with statutory requirements and Title 22 regulations. In addition, the loss of this position will reduce the capacity to develop and implement a health systems framework for coordination and integration of local MCAH, home visiting, and other community programs that make up the local MCAH public health system.

> Three Associate Governmental Program Analysts - The elimination of these positions will limit the ability of MCAH to monitor, maintain, and provide technical assistance to LHJs, CBOs, and contractors.

> Two Staff Service Analysts - The elimination of these positions will limit the ability of MCAH to monitor, maintain, and provide technical assistance to LHJs, CBOs, and contractors.

> Public Health Medical Officer III– The elimination of this position limits the ability of MCAH to address the rising rate of maternal morbidity and mortality, a newly emerged health issue in the last decade.

Primary and Rural Health Division (PRHD)

In FY 2012/13 the PRHD will be reduced by $373,000 and eliminate 4.0 state positions at DHCS. The PRHD provides training, technical assistance, and limited funding to primary care providers in underserved areas throughout the state to sustain and improve the primary care infrastructure. This assistance enables primary care clinics to plan and evaluate their systems of primary and preventive care delivery to meet the needs of high risk, underserved populations, including women and

children. Targeted clinics include those located in rural areas and clinics that serve migrant farmworkers and American Indians. Additionally, the PRHD supports the implementation of the American Indian Infant Health Initiative (AIIHI). This program provides home visitation services to high-risk pregnant and parenting American Indian families. Services include assessment, counseling, referrals/follow up to medical and social services providers. The following are the positions that will be eliminated:

> Word Processing Technician – Elimination of this position will impact contract oversight and delivery of annual reports. Primary care clinics will be additionally impacted due to delays in Tribal notification of Medi-Cal updates.

> Associate Governmental Program Analyst – Elimination of this position will cause delays in grant execution, limited support to DHCS divisions for Tribal notices, and delays in providing technical assistance and support to Indian health clinics.

> Health Program Specialist I – Elimination of this position will decrease support to community health centers, Federally Qualified Health Clinics, rural health clinics, and other rural health providers for funding applications.

> Nurse Consultant III (Specialist) – Elimination of this position will delay providing clinical technical assistance, limits staff support to mandated Indian health advisory group, and delays development and updates of policy and procedures.

Audits and Investigations (A&I) Division
A & I performs audits on MCAH local contracts to ensure fiscal accountability and that federal requirements are met. A proposed reduction of $182,000 to A&I will result in a reduction in the number of audits to what has historically been performed.

> APN
Reductions and redirections of the Title V funds resulted in a 25% reduction in the APN for FY 2011/12 and complete elimination by July 2012.

> CDAPP
For FY 2011/12 funding for CDAPP was reduced by 50% to about $600,000 and the program will be eliminated starting July 2012. A resource and training center was contracted to provide resource materials, educational webinars and maintain the CDAPP website and listings of local CDAPP affiliates.//2013//

B. Budget

Since the enactment of the Omnibus Budget Reconciliation Act 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements. The California Title V agency will continue to do so in the coming year.

The proposed allocation of Title V funds for California for FFY 2011 is $43,315,317. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $12,800,106 (29.55 % of the total), preventive and primary services for children to receive $14,272,848 (32.95 %) and CSHCN to receive $13,603,489 (31.41%).

/2012/The proposed FFY 2012 allocation is $42,300,760 Preventive and primary services for pregnant women, mothers, and infants are designated to receive $13,160,420 (31.11 % of the total), preventive and primary services for children to receive $13,476,402 (31.86 %) and CSHCN to receive $13,235,668 (31.29%). //2012//

/2013/The FFY 2013 allocation is $41,389,219. Services for pregnant women, mothers, and infants are designated to receive $13,055,182(31.54 %) services for children to receive $13,573,945 (32.80 %) and CSHCN to receive $12,560,334 (30.35%). The required match is $31,041,914 California's FFY 2013 budget for Title V MCH programs includes $1,306,322,819 in state funds.//2013//
/2014/The FFY 2014 allocation is $35,292,014. Services for pregnant women, mothers, and infants are designated to receive $11,139,029(31.56 %) services for children to receive $11,520,848(32.64 %) and CSHCN to receive $10,811,999 (30.64%). The required match is $26,469,010 California's FFY 2014 budget for Title V MCH programs includes $1,402,450,145 in state funds.//2014//

> State Match/Overmatch
California expects to receive $43,315,317 in Federal Title V Block Grant funds for FFY 2011. The required match is $32,486,488. California's FFY 2011 expenditure plan for MCAH programs includes $1,290,479,684 in state funds. The dramatic increase in California's expenditure plan for FFY 2011 for the provision and coordination of services to the Title V MCAH population is due to the reporting of CSHCN data on actual expenditures. Previously the Electronic Data Systems (EDS) MR 922 report was used to provide the data for these numbers. However, a change to the EDS system for this report changed something in the data compilation and the numbers were not correct as they were grossly understating the expenditure data. Therefore, numbers from previous years' data submission to this year's data submission show a marked increase for the expenditures as the number is projected upon the actual expenditure data from FY 09/10 instead of the MR 922 report. Reporting of expenditure data has been updated and no longer uses the report it used in prior years. //2011//

/2012/ California expects to receive $42,300,760 in Title V funds for FFY 2012. The required match is $31,,725,5701 California's FFY 2012 budget for Title V MCH programs includes $1,366,907,980 in state funds.//2012

>Administrative Costs Limits
In FFY 2011 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2011, California will expend only 6.09 % of Title V funds on administrative costs.

/2012/ In FFY 2012 /2013/and 2013//2013// no more than 10 % of the Title V MCH Block Grant funds will be used for administrative costs and California will expend only 5.74% /2013/ and

5.31%, respectively,//2013// on administrative costs.//2012// /2014/ Administrative costs will be 5.16% of the total allocation for FFY 2014.//2014//

>Definition of Administrative Costs
In this Application, administrative costs are defined as the portion of the Title V dollars used to support staff in the MCAH Division Operations Sections. Funds supporting State program and data staff (but not administrative staff) in MCAH and CMS are considered to be program rather than administrative costs.

Administrative costs include staff and operating costs associated with the administrative support of MCAH. These support functions include, but are not limited to, contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

>"30-30" Minimum Funding Requirement
At least 30 percent of the MCH Title V Block Grant funds will be used for children's preventive and primary care services delivered within a system which promotes family-centered, community-based, coordinated care. At least 30 percent of the Title V Block Grant funds will be used to provide services to CSHCN delivered in a manner which promotes family-centered, community 187 based, coordinated care.

In some cases, the CDPH uses estimates to assess expenditures for both individuals served and the types of services provided. These estimates are based on the target population and program activities authorized in statute, excluding the State budget, and specified in the scope of work for each contractor. Requiring contractors to bill according to actual amounts spent on each type of individual served and by service provided is not possible within current administrative and fiscal policies. Changing State contractual policies would result in undue financial and administrative hardship to local governments and non-profit community-based organizations. This added burden without increased funding would result in many of them not being able to continue to provide needed services to women and children in the state.

/2013/ Since FY 2008/09, LHJ quarterly time surveys were implemented to ensure that the "30-30" minimum funding requirement is met. //2013//

>Maintenance of State Effort
CDPH has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health services.

It is the State's intent to ensure that State General Fund contributions to these local programs, which are also funded in part by the Federal Title V Block Grant, be administered by MCAH and CMS.

The State's General Fund contribution for FFY 2011 is $1,290,479,684 which is $1,203,320,934 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989.

/2012/The State's General Fund contribution for FFY 2012 is $1,366,907,980 which is $1,279,749,230 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989. //2012// /2014/The State's General Fund contribution for FFY 2012 and FFY 2014 is $1,279,749,230 and $1,315,291,395 greater than for base year FFY 1989...//2014//

>Budget Impact
The combined effect of the state's budget deficit and loss of revenues due to the economic downturn resulted in a budget gap of $26.3 billion for Fiscal Year 2009-10. All California State General Funds (SGF) for MCAH were eliminated effective July 1, 2009, reducing the state and local MCAH Program budget by $20.3 million in SGF and $12 million in related matching Federal Title XIX funds.

The loss of SGF to MCAH Programs, BIH, AFLP, CPSP and CBDMP has resulted in deep cuts to local staffing, public health prevention activities, and the numbers of clients served. At the local level, the loss of SGF has reduced or eliminated the capacity of LHJs to provide public health nurse home visiting programs, as well as the LHJs' ability to provide outreach to the community by educating the MCAH population regarding such issues as SIDS, domestic violence, injury prevention, safety promotion measures and accident prevention, preconception care, early prenatal care, STDs and family planning, access to care, oral health, breastfeeding, childhood nutrition, childhood obesity, and guidance and support.

Statewide, the LHJs allocate approximately 3.25% of Public Health Realignment funds to local MCAH programs. In FY 2006-07, total Public Health Realignment funds transferred to counties equaled $1,538,651,128. In FY 2008-09, total Public Health Realignment funds transferred to counties equaled $1,372,049,262 and FY 2009-10 will be further reduced to approximately $1,310,000,000.

Given that the current fiscal year's public health realignment funding distributions are projected to be approximately $62 million lower than FY 2008-09 distributions, the MCAH reductions in FY 2009-10 can be estimated to be approximately $2,015,000 in realignment funding and an additional $705,000 in matching Title XIX across local MCAH, BIH and AFLP programs.

>State MCAH Support
MCAH has lost the ability to leverage SGF to draw down Title XIX matching funds. The loss of $3.5 million resulted in an additional loss of approximately $1 million in federal Title XIX matching 188 funds. It reduced capacity at the local level to collect data has impacted the State's ability to document positive program outcomes and identify and address needed changes. State staffing levels were reduced -- vacant positions have not been filled, creating added work burden for remaining State staff. Resources were reduced to coordinate services across LHJs and advocate for vulnerable at-risk MCAH populations. There was an overall reduction in statewide meetings, which are essential to assuring statewide program equality, information sharing, training, and problem solving. There was travel reduction for state staff to audit and monitor budgets and operations and provide crucial technical assistance.

/2012/State General Fund monies have not been reinstated. Title V federal funds were reduced in FFY 2011, which has resulted in a reduction to local allocations for BIH and AFLP. //2012//

>CBDMP and CPSP
Of the $3.5 million SGF budgeted for State Operations, $1.6 million was for CBDMP. Reduced funding has caused the program to be drastically restructured. Budget cuts to CPSP has resulted in decreased outreach to promote access to early prenatal care, decreased recruitment and training of new CPSP providers or provision of technical assistance to existing and new CPSP providers. Also, there is reduced monitoring and evaluation of CPSP providers.

>Local MCAH Programs
The elimination of $2.1 million in SGF from local MCAH programs resulted in a loss of $2.1 million in Title XIX federal matching funds. Total local MCAH funds lost as a direct result of the elimination of SGF and the related Title XIX federal match was $4.2 million statewide in FY 2009-10. For every $1 of SGF cut, LHJs have experienced an additional $1 in Title XIX matched funding. Statewide, in addition to the loss of SGF and the related Title XIX match, local funds budgeted were reduced by $1.9 million in FY 2009-10. Title XIX match to local funds will be affected by the reduction in local funds, and is estimated to be a reduction of approximately $600,000, based on projected invoices.

/2012/The reduction to Federal Title V allocation to the State did not affect local MCAH program budgets for SFY 2011-12, and there were no shifts in funding from MCAH to other Title V programs. SGF remains at zero, and both state and local agencies continue to operate with less money and staff due to hiring freezes and lack of funds.//2012//

>AFLP
In 2009-2010, $10.7 million SGF and $5.1 million related Title XIX were eliminated for AFLP. In the 2009-2010 fiscal year, AFLP reductions resulted in 12,027 fewer clients served -- a 70% reduction in clients served. AFLP agencies experienced staff reductions of 170 full-time equivalent (FTE) statewide. Three AFLP programs -- Riverside, San Bernardino, and Siskiyou Counties -- have been discontinued in FY 2009-10 as a result of their inability to continue activities at the current funding levels.

/2012/Due to a reduction to the Federal Title V allocation to the States in FFY 2011, the total AFLP allocation to local agencies for SFY 2011-12 has been reduced by $250,000. This will reduce the number of clients served by AFLP agencies and put further stress on local programs, which are reported to be experiencing increasing demands for services due to funding reductions to or elimination of other programs like California's CalLearn Program, which provides related services to the AFLP population. //2012//

/2013/ In FFY 2012, 2 AFLP sites discontinued operations. Funding for AFLP programs will be reduced by $1,900,000 through reductions to local assistance resulting in 13,435 fewer person-months of service in FFY 2013.//2013//

>Black Infant Health Program (BIH)

The 2009-2010 California budget eliminated $3.9 million SGF and $3.7 million related Title XIX to BIH programs statewide. Budget reductions have caused two sites, Riverside and San Bernardino Counties, to close.

/2012/Due to a reduction to the Federal Title V allocation to the State in FFY 2011, the total BIH allocation to local agencies for SFY 2011-12 had been reduced by $140,000. These reductions add to the difficulties faced by local agencies due to the loss of the SGF in SFY 2009-10 and continued lower revenues from state realignment funds.//2012//

>CMS
CMS has lost 30 positions since the 2007 reorganization of DHS into CDPH and DHCS, which together with operating expense reductions, have resulted in unmet workload and backlogs in all CMS programs including CCS. Backlogs for some CCS eligibility determinations and service authorizations in CMS Branch Regional Offices that support dependent county CCS programs now exceed three months. As county revenues from sales, vehicle licenses, and property taxes have declined, counties have been unable to support baseline levels of services in their public health, public assistance, and safety net health care programs. The State's actions to contain expenditures, including 189 capping allocations of local assistance funds for CCS county administration and the CCS MTP, have exacerbated these challenges. County CCS programs maintain that the reimbursement they receive under these funding caps is inadequate for case management and care coordination, and they are cutting staff by attrition and layoffs. Some providers report that eligibility determination and authorization delays, along with the unavailability of CCS staff to assist them with claiming and reimbursement problems, may force them to stop participating in the CCS program. As with many other essential safety net programs, CCS is having difficulty meeting the needs of the CSHCN population. DHCS is working with CCS stakeholders to redesign the CCS program to more efficiently and effectively provide services to CSHCNs while maintaining access, quality of care, and optimal outcomes.

/2013/ CMS will see a reduction of $200,000 in administrative costs and $405,000 will be reduced from HRIF. //2013//

> Budget Outlook
All signs point to another tough budget year for California for 2010-2011. The governor had included $6.9 billion in federal dollars in his January budget plan, but so far the state has received just under $3 billion. The state was hoping for unexpected gains in state revenues to significantly cut the budget deficit. However, revenues from personal and corporate taxes fell $3.6 billion short of what was projected for April 2010 the month when the bulk of revenues are collected. A significant carryover of losses from 2008 to 2009 that brought down revenues from capital gains and weakness in small business income partly explains the shortfall. That means the state's budget deficit, which at the start of 2010 was projected at $20 billion and dipped to about $18.6 billion after some midyear actions by the Legislature, could exceed the original estimate. And state legislators have stated that they do not intend to seek higher taxes this year to bridge the gap. This leaves lawmakers and the governor to face decisions such as the wholesale elimination of certain programs. More than ever, California faces the specter of this being the most damaging year for the health of children, the poor and the disabled.

Recent budget actions and proposals have targeted cutting MediCal services, HF and safety-net programs for low-income women, children and those with disabilities. CalWORKS, the state's version of TANF, provides cash assistance for low-income families with children, while helping parents find jobs and overcome barriers to employment. CalWORKs is primarily a children's program: Kids make up more than three out of four recipients (77.9 percent), equivalent to 1.1 million of the more than 1.4 million Californians who are projected to receive CalWORKs cash assistance in 2010-11. Women comprise more than three-quarters (77.7 percent) of all adult recipients, and women make up an even larger share (92.5 percent) of single parents who receive cash assistance. The SSI/SSP Program provides cash assistance to help low-income seniors and people with disabilities meet basic living expenses. More than half (57.3 percent) of SSI/SSP recipients are women, equivalent to approximately 666,500 of the 1.2 million adults who are projected to receive SSI/SSP grants in 2010-11. The In-Home Support Services (IHSS) Program helps low-income seniors and people with disabilities live safely in their own homes, thereby preventing more costly out-of-home care. More than three out of five IHSS recipients (63.1 percent) are women and girls, equivalent to approximately 300,500 who are projected to enroll in IHSS in 2010-11. Women also make up the majority of caregivers that receive IHSS employment. IHSS provides a range of services, including assistance with dressing, bathing, and medications in addition to domestic tasks such as cleaning, shopping, and meal preparation. Women comprise more than three out of five adults enrolled in the major safety-net programs that provide these benefits and services.

Medi-Cal, the state's version of Medicaid, provides comprehensive health coverage to 7.2 million Californians, including reproductive and prenatal care, and is a key component of California's safety net for low-income families. Women comprise nearly two-thirds of adult enrollees in the program. In addition, more than half of women enrolled in the program are in their peak reproductive years, a period where women seek more health services than men. Medi-Cal is also an important source of affordable coverage for unmarried women and their children. Nine out of 10 single parents enrolled in Medi-Cal are women. Because women make up a large share of adult Medi-Cal enrollees, women and their children are disproportionately affected by reductions to the program. State lawmakers made significant cuts to MediCal, CalWORKs, SSI/SSP, and 190 IHSS in 2009. Governor Schwarzenegger's Proposed 2010-11 Budget in January 2010 includes even deeper reductions to these programs to help close the budget gap identified by the Governor in January.

Nearly one million children and teens in California depend on HF, the state's version of SCHIP, a federal-state partnership for working poor families. HF was launched in 1998 for parents who earn too much to receive Medi-Cal coverage but who are priced out of the private insurance industry. One way for California to keep programs alive, including HF is getting the $6.9 billion in federal funds. Since California has not received the anticipated federal dollars, the threat to eliminate HF based on the May revise budget proposal is becoming more imminent. These health and safety net programs are not administered by Title V although Title V funding is used to support the maternal and child health needs of populations that utilize these programs. The wholesale elimination of certain programs for children, the poor and the disabled will further exacerbate and create additional challenges for existing Title V administered programs to meet the needs of the vulnerable population it serves.

/2013/ The State's budget shortfall for FY 2012/13 stands at $15.7 billion.

The State's economic recession hit single women supporting families particularly hard with the largest decline in their average workweek in at least two decades. [54]

Funding for K-12 schools can have an additional $5.6 billion dollars in cuts by November 2012 if the tax initiative to increase state taxes is not passed.

Continued shortfalls threaten programs and services that California's women and their families depend on. The budget contained proposals for downsizing and achieving efficiencies including reorganization of State government, elimination of some 700 legislative reports and staff furloughs.//2013//

/2014/ The 2013-14 California budget highlights investments in education and a resolution for a timely state-based Medi-Cal expansion as required by ACA. It shifts pregnant women and recent legal immigrants currently in state-funded programs onto private insurance through Covered California.

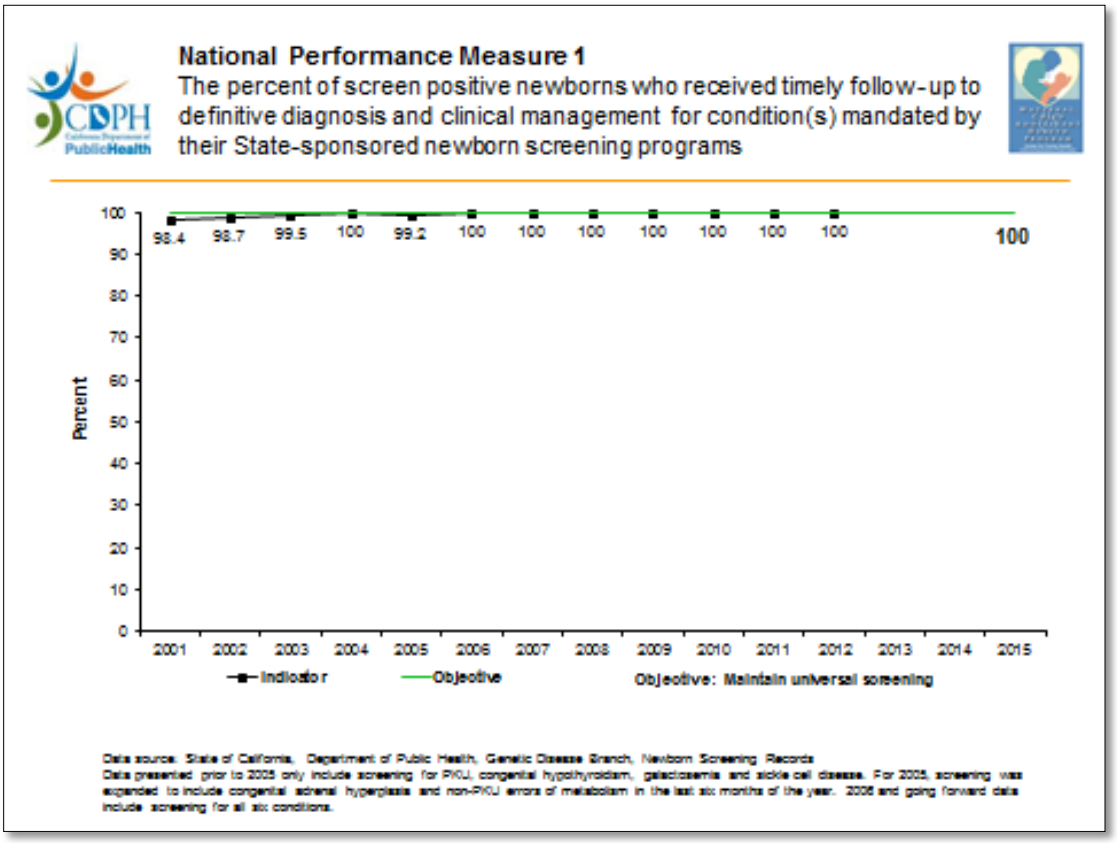
Federal budget cuts or "sequestration" began on March 2013 as an austerity fiscal policy with reductions starting in FY 2013 to FY 2021. It is projected that California's public health would lose about $2.6 million in funds to help upgrade its ability to respond to public health threats including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events.//2014//

/2015/ The 2014-15 budget reflects full implementation of healthcare reform which include expansion of Medi-Cal. The budget maintains a 10% cut to Medi-Cal providers while partially rolling back the retroactive portion of this cut. It also reflects a redirection from counties to the state, funding that counties currently use to provide health care to uninsured, low-income residents.//2015/

Data Charts

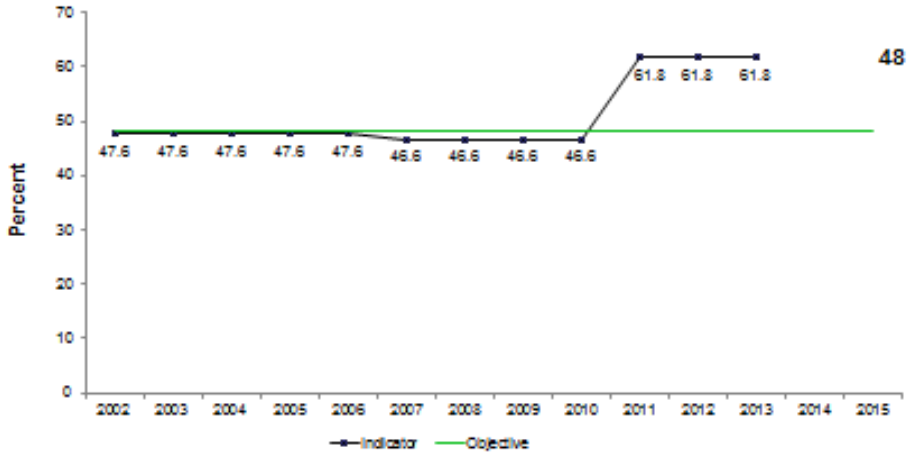
The charts show the trend line for health measures and indicators reported in the Title V Block Grant Application/Annual Report. Proposed targets or annual objectives for performance measures are included in the trend charts.

National Performance Measures



National Performance Measure 2

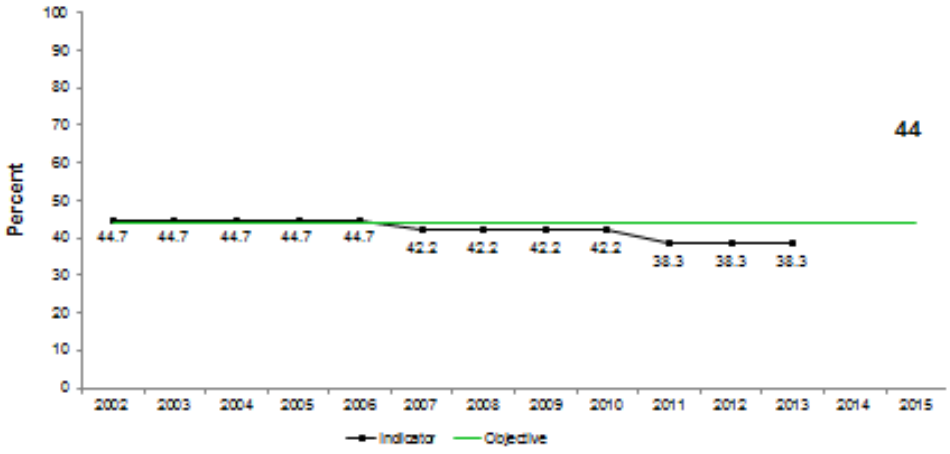
Percent of children with special health care needs age 0 to 18 years of age whose families partner in decision making at all levels and are satisfied with the services they receive



Data source: Centers for Disease Control and Prevention. National Center for Health Statistics, State and Local Area Integrated Telephone Survey. National Survey of Children with Special Health Care Needs

National Performance Measure 3

Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home



Data source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey of Children with Special Health Care Needs

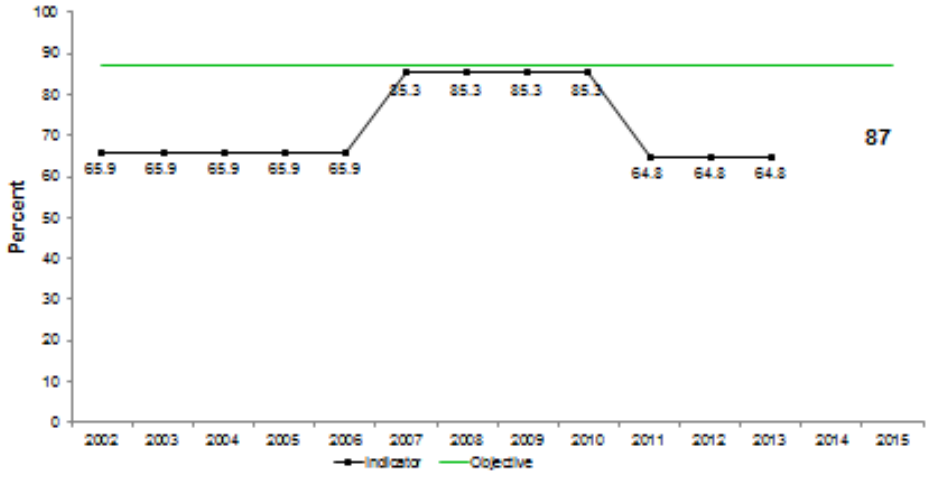
National Performance Measure 4

Percent of children with special health care needs age 0 to 18 whose families have adequate private and /or public insurance to pay for the services they need

Data source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs.

National Performance Measure 5

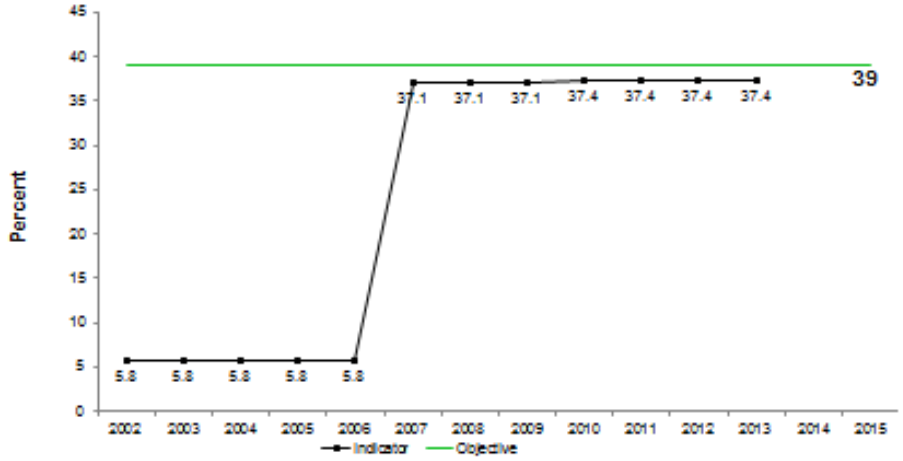
Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily



Data source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs

National Performance Measure 6

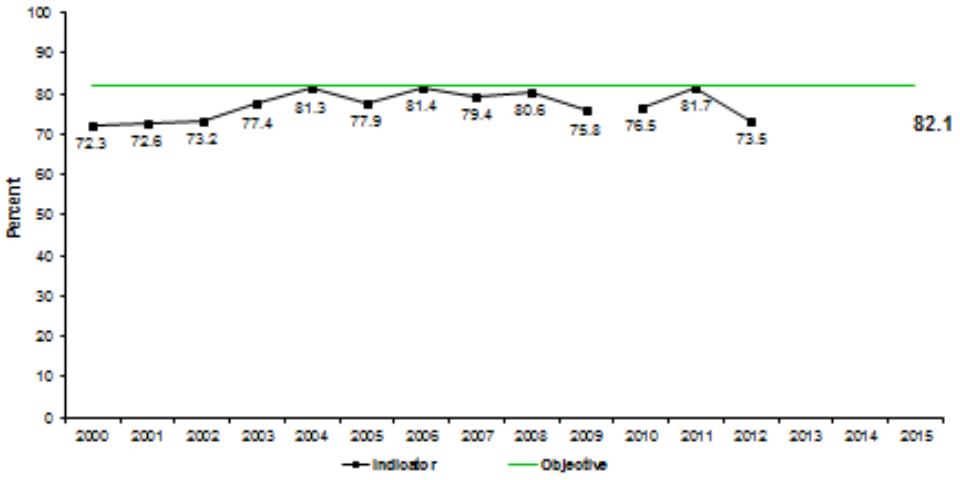
Percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence



Data source: Centers for Disease Control and Prevention. National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs

National Performance Measure 7

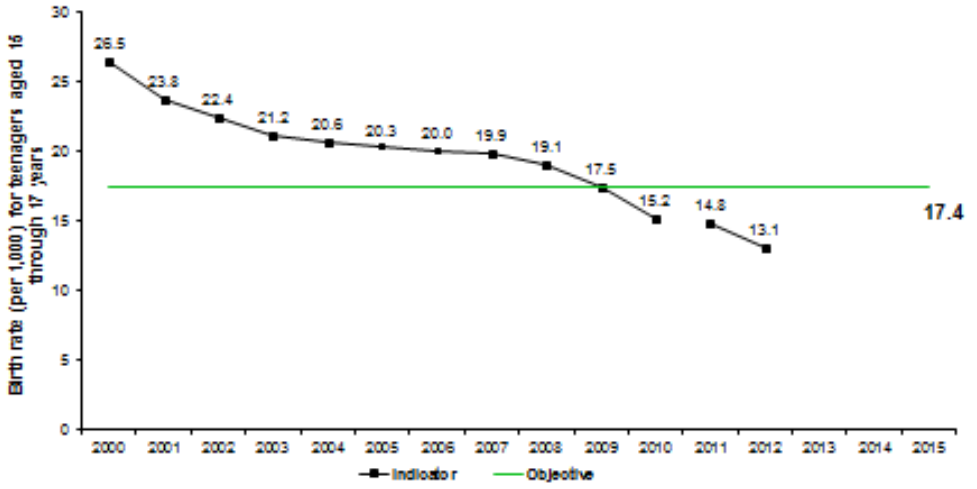
Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diptheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B



Data source of percent immunized: CDC, U.S. National Immunization Survey, Estimated Vaccination Coverage with 4:3:1:3:3 Among Children 19-35 Months of Age by Race/Ethnicity and by State and Local Area. 2010-2011 data should not be compared to previous years' data due to change in the way Hepatitis B vaccine is measured

National Performance Measure 8

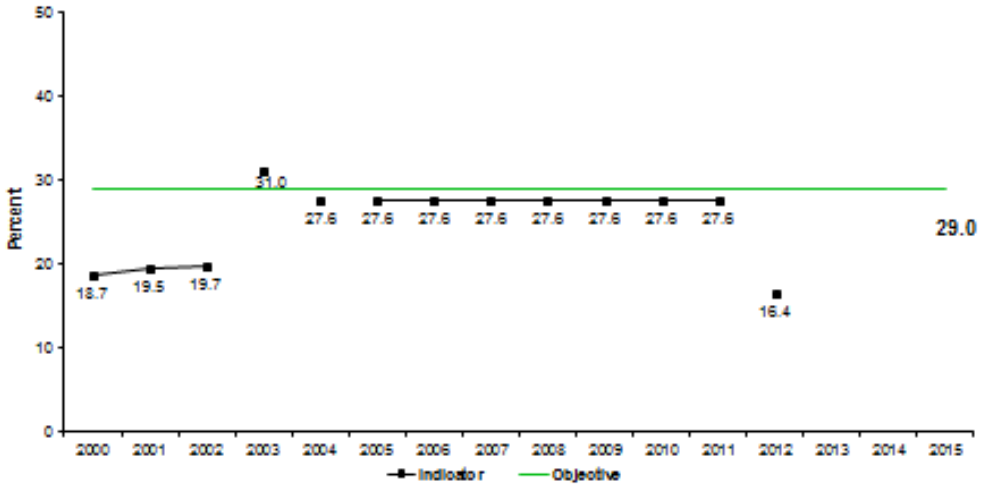
Birth rate (per 1,000) for teenagers aged 15 through 17 years



Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data sources: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master Files. Denominator: (2011) State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.; (2000-2010) State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

National Performance Measure 9

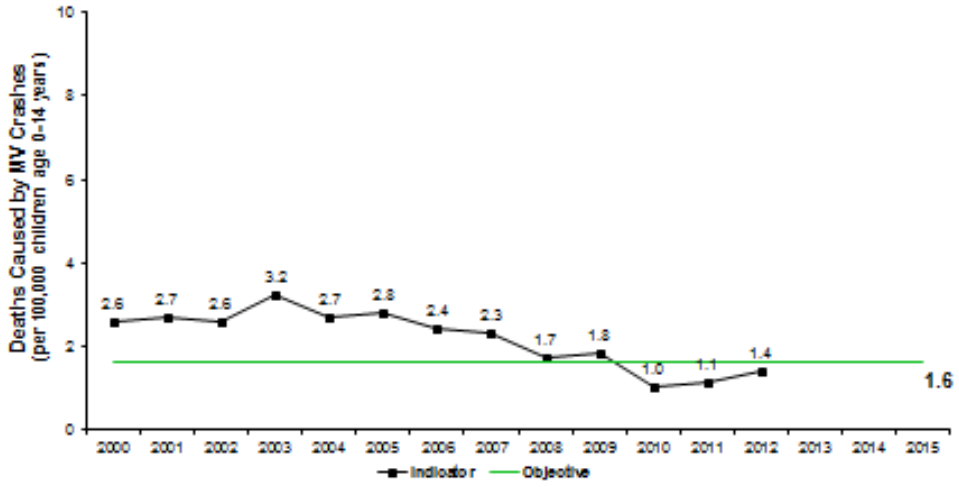
Percent of third grade children who have received protective sealants on at least one permanent molar tooth



Notes: 2000-2002 data are the California Department of Health Services, Medical Care Statistics Section and Delta Dental Plan, based on 7 to 8 year-old eligible children who received a sealant for that year. Data for 2003 was based on preliminary results of 2005 California Smile Survey conducted by the California Dental Health Foundation. Data starting 2004 was based on the Dental Health Foundation, California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade children. The denominator source is the State of California, Department of Education, third graders in 2005.

National Performance Measure 10

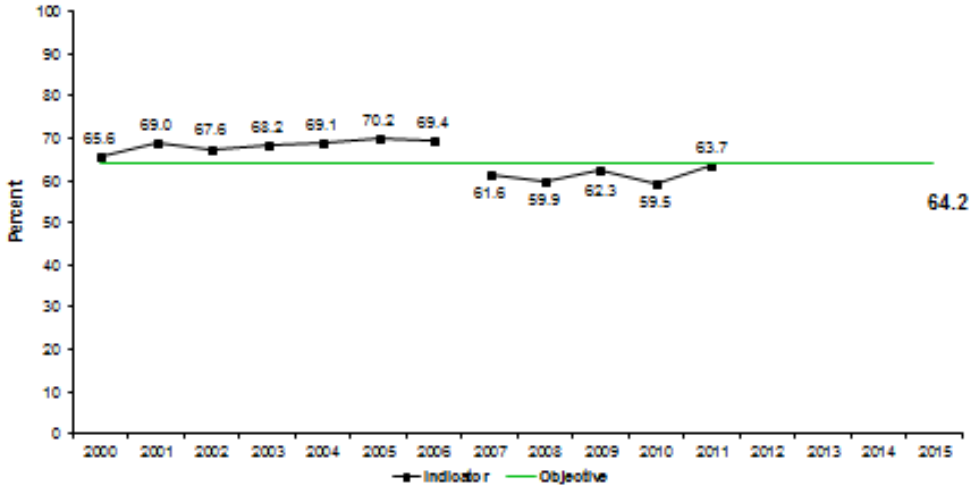
Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children



Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data sources: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Death Statistical Master Files (The ICD-10 codes for fatal MV traffic injuries are: V20-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.5), V89.2). Denominator: (2011) State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.; (2000-2010) State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

National Performance Measure 11

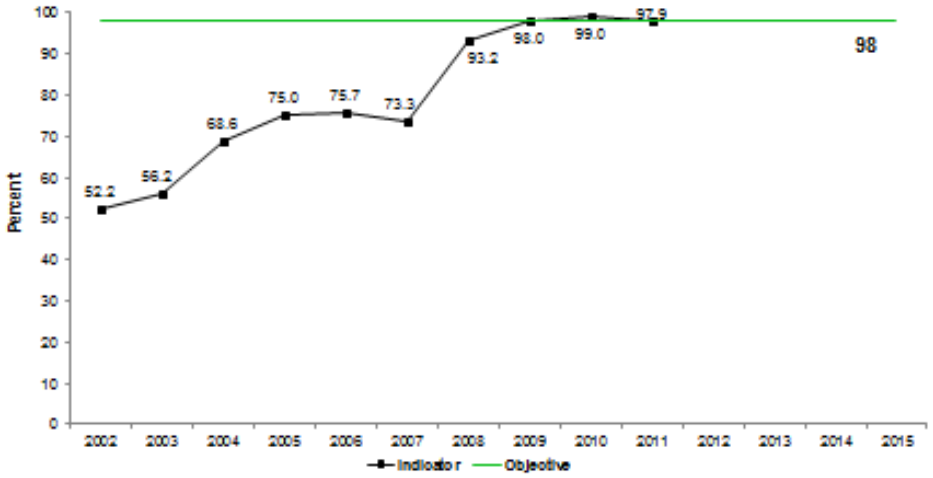
Percent of mothers who breastfeed their infants at 3 months of age



Data source: State of California, Department of Public Health, Maternal and Infant Health Assessment Survey (MIHA), 2000-2010. Beginning in 2007, California reports the percent of women who breastfeed their infants at 3 months of age. Data should not be compared to prior years, which presents the percent of mothers who breastfed their infants at 2 months of age.

National Performance Measure 12

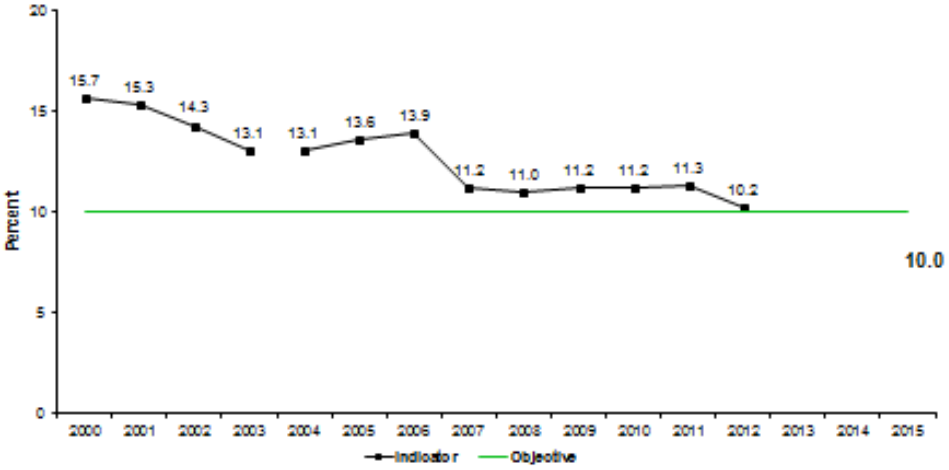
Percentage of newborns who have been screened for hearing before hospital discharge



Data source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data. Numerator: Number of newborns who have been screened for hearing before discharge. Denominator: Number of live births by occurrence in California.

National Performance Measure 13

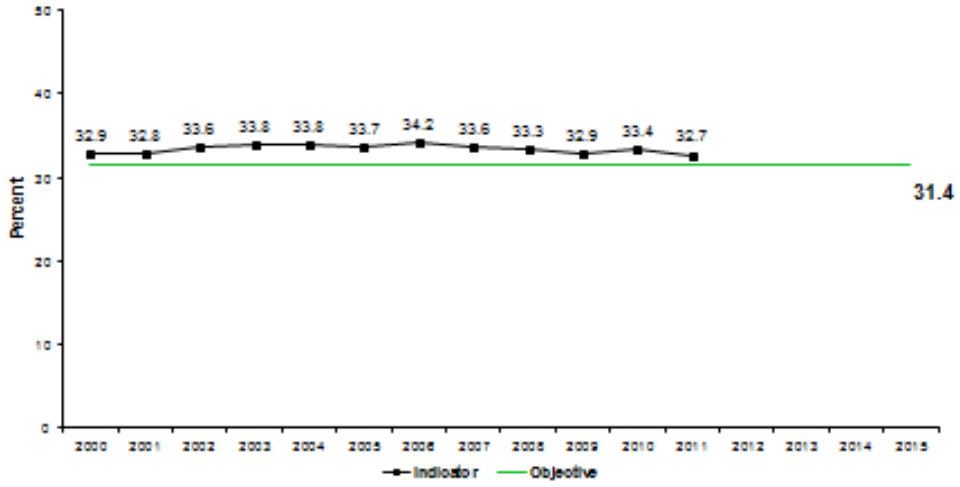
Percent of children without health insurance



Data source: Data from 2000 to 2002 were from the University of California at Los Angeles, Center for Health Policy Research and based on the Current Population Survey. It includes children from 0 to 18 years of age. Data for 2003 to the current year were from the Kaiser Family Foundation analysis of the Current population survey for children 0 to 18 years of age.

National Performance Measure 14

Percent of children, ages 2 to 5, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile

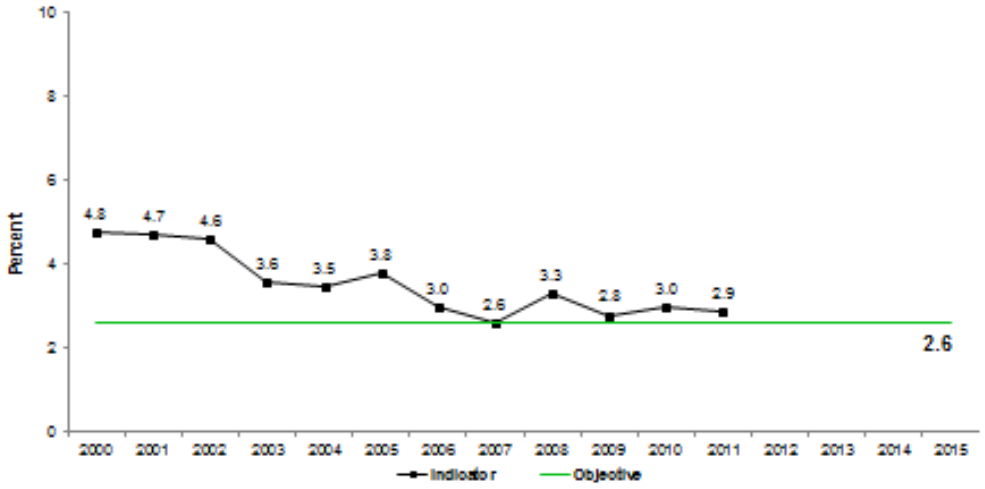


Data Source: CDC, Pediatric Nutrition Surveillance System

Note: Overall percent with BMI at or above the 85th percentile (i.e. Overweight/Obese) is computed by summing the percent of children age 24-59 months that are Overweight: >= 85th to <95th percentile BMI-for-age and gender, plus the percent of children that are Obese: >= 95th percentile BMI-for-age and gender.

National Performance Measure 15

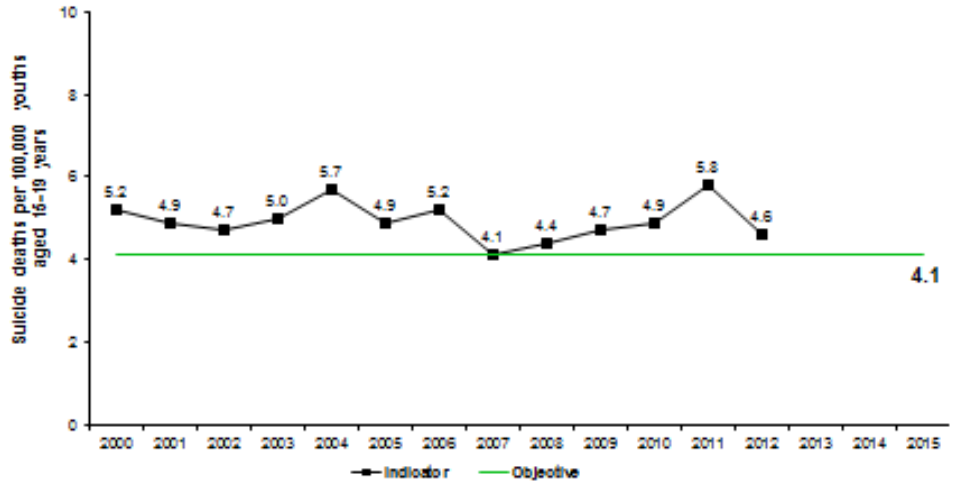
Percent of women who smoke in the last 3 months of pregnancy



Data source: Maternal and Infant Health Assessment survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy.
Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in that year.

National Performance Measure 16

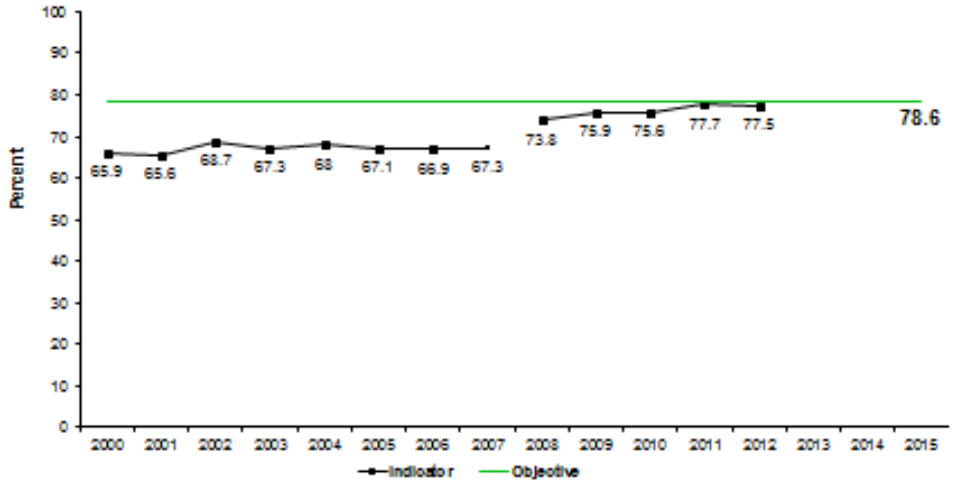
The rate (per 100,000) of suicide deaths among youths aged 15 through 19 years



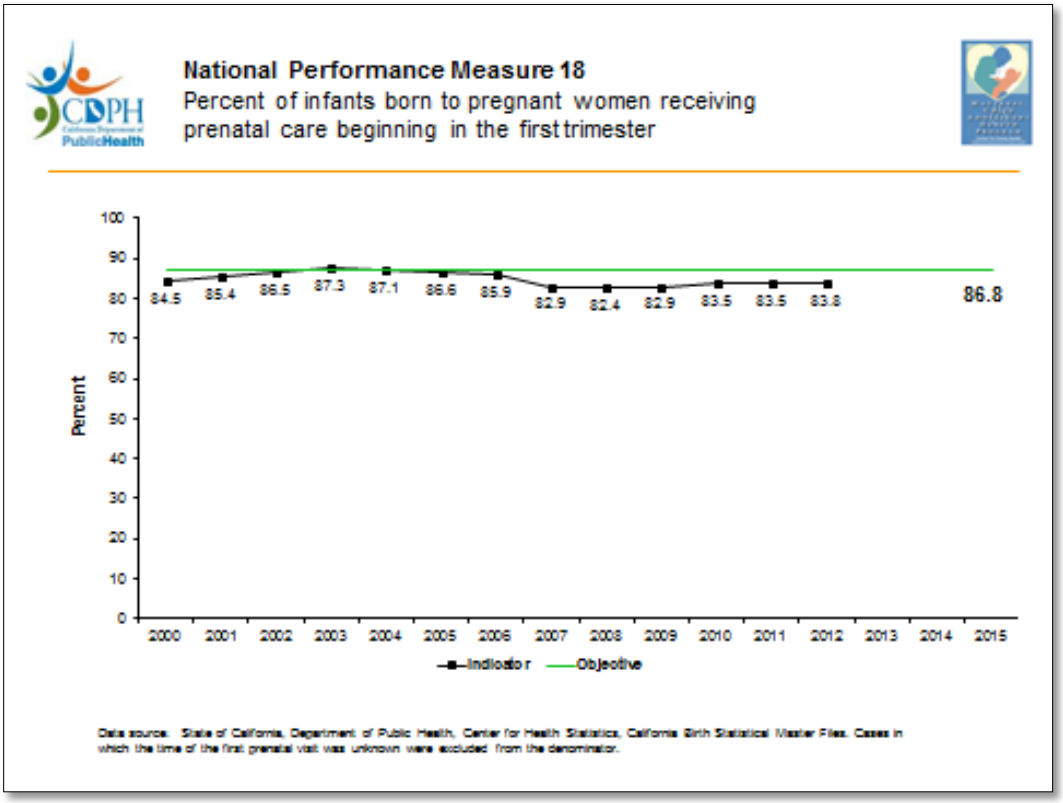
Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data sources: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Death Statistical Master File (ICD-10 Group Cause of Death Codes 331-337). Denominator: (2011) State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.; (2000-2010) State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

National Performance Measure 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates



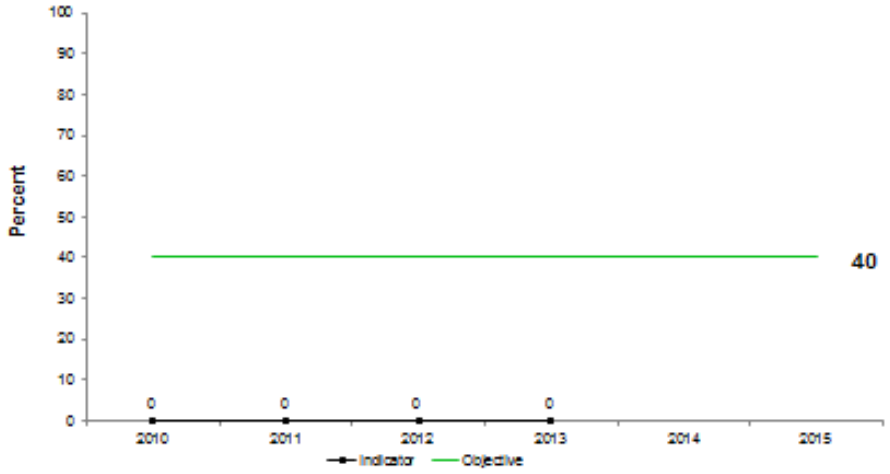
Data sources: State of California, Department of Public Health, Center for Health Statistics, Birth Statistical Master File, and State of California, Department of Health Care Services, California Children Services (CCS). Data for 2008-2011 should not be compared to data reported in previous years due to a change in exclusion criteria and methodology.


National Performance Measure 18
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
Percent
100
90
80
70
60
50
40
30
20
10
0
84.5
85.4
86.5
87.3
87.1
86.6
85.9
82.9
82.4
82.9
83.5
83.5
83.8
86.8
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
Indicator
Objective
Data source: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master Files. Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

State Performance Measures

State Performance Measure 1

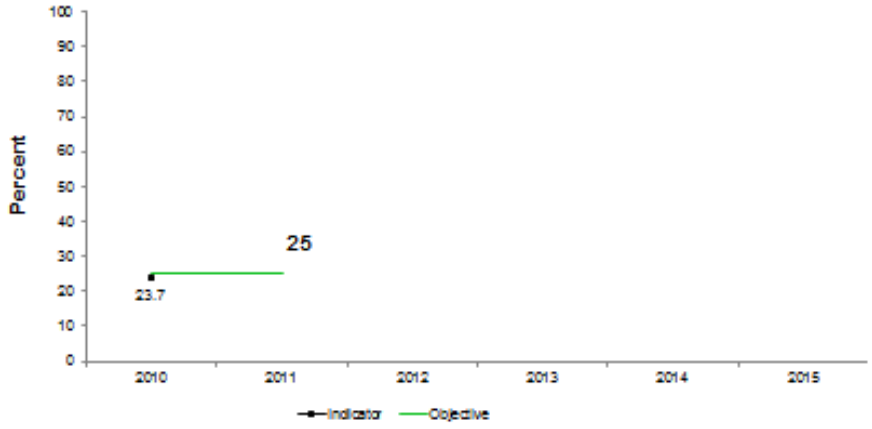
The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system



Data source: CMS Net data for 56 counties and data from local county CCS programs for the remaining 2 counties.

State Performance Measure 2 (inactivated starting 2011)

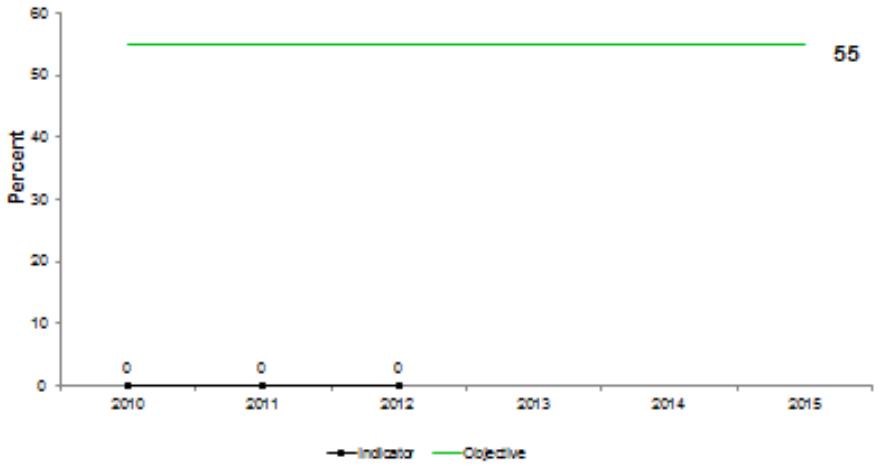
The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care.



Data source: CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2008-09

State Performance Measure 3

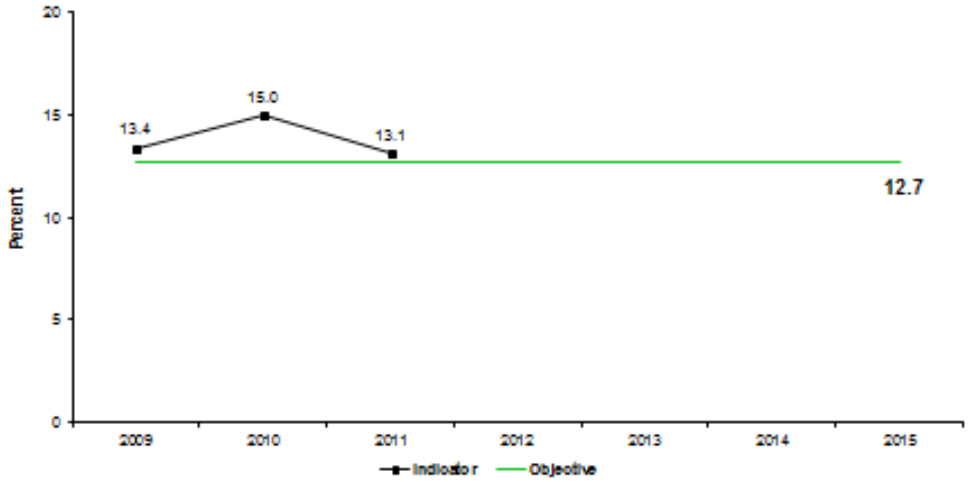
The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey



Data source: A Statewide CCS family satisfaction survey is currently under development

State Performance Measure 4

Percent of women with a live birth who reported binge drinking during the three months prior to pregnancy

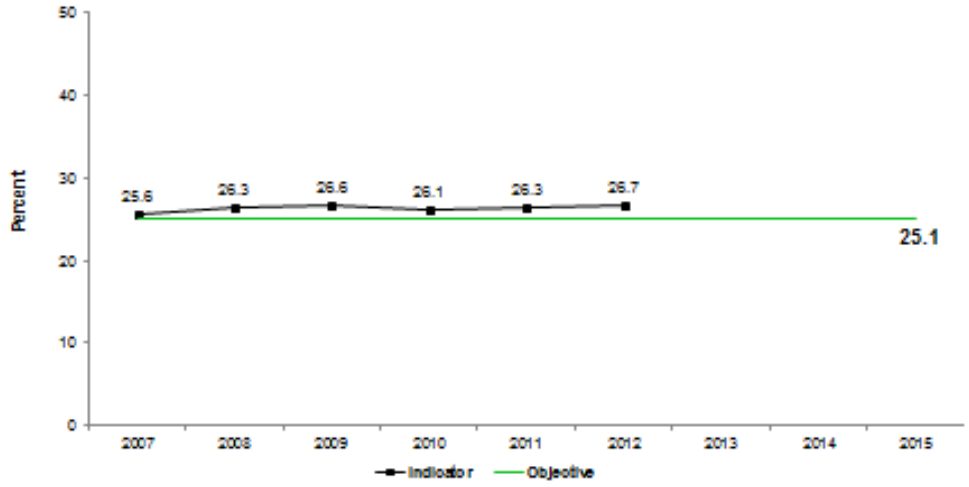


Data source: Maternal and Infant Health Assessment survey, MCAH Program, California Department of Public Health. Numerator: The number of women who reported that they had 4 or more drinks in one sitting at least once during the 3 months before they got pregnant with their most recent live-born infant. Denominator: The number of women who reported whether or not they had 4 or more drinks in one sitting at least once during the 3 months before they got pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past 2 years.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in that year.

State Performance Measure 5

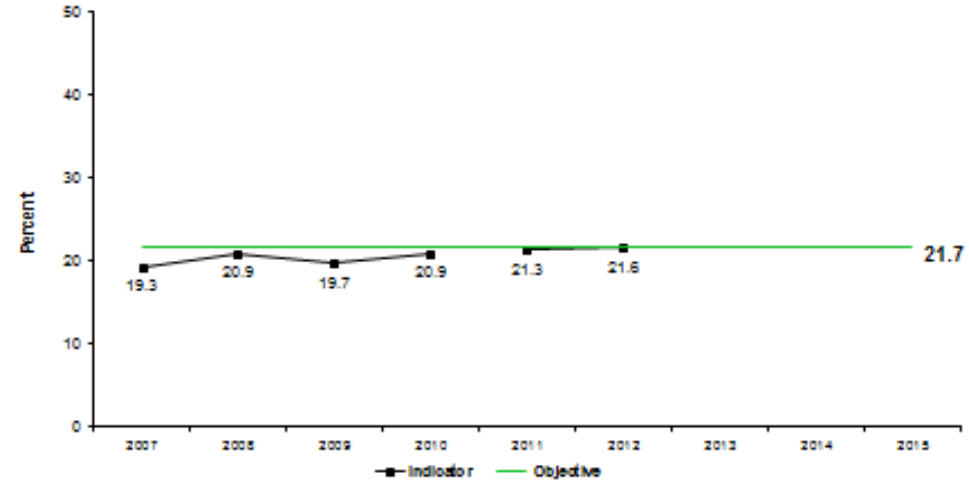
Percent of cesarean births among low risk women giving birth for the first time



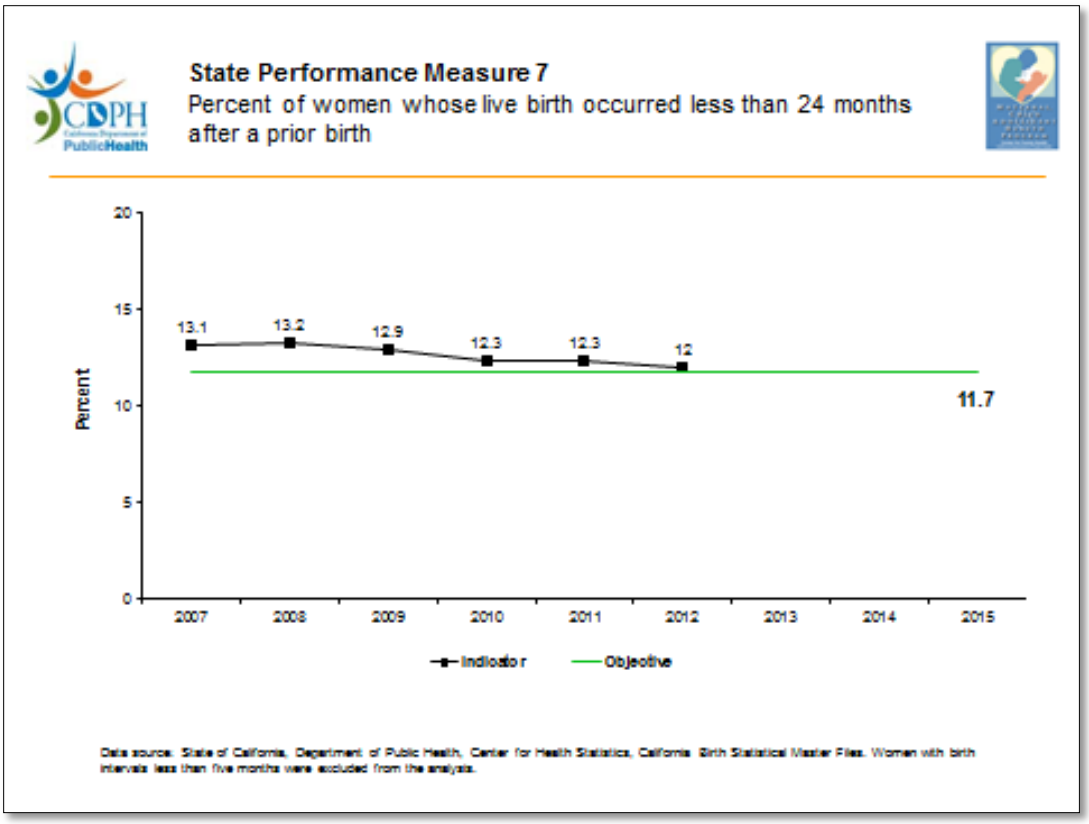
Data source: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master Files. Numerator: The number of births delivered by cesarean section to low risk women giving birth for the first time. Denominator: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California.

State Performance Measure 6

Percent of women of reproductive age who are obese

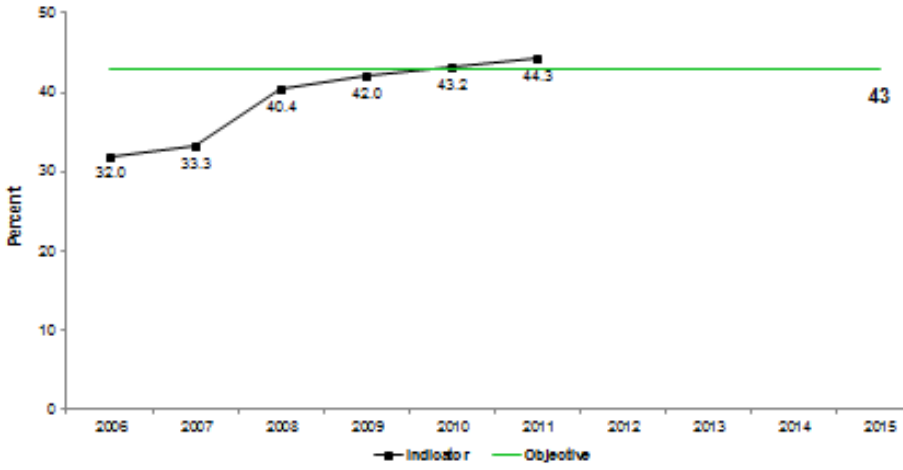


Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data source: California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator: The number of women aged 15-44 years who have a body mass index (BMI) greater than or equal to 30 kilograms body weight/ body surface area in square meters (kg/m2). Denominator: The number of women aged 15-44 years for whom BMI can be calculated. Numerator and denominator are weighted to the representative number of resident women in the state and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or > 84 in., weight < 75 lbs. or > 299 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information).


State Performance Measure 7
Percent of women whose live birth occurred less than 24 months after a prior birth
Percent
20
15
10
5
0
13.1
13.2
12.9
12.3
12.3
12
11.7
2007
2008
2009
2010
2011
2012
2013
2014
2015
Indicator
Objective
Data source: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master Files. Women with birth intervals less than five months were excluded from the analysis.

State Performance Measure 8

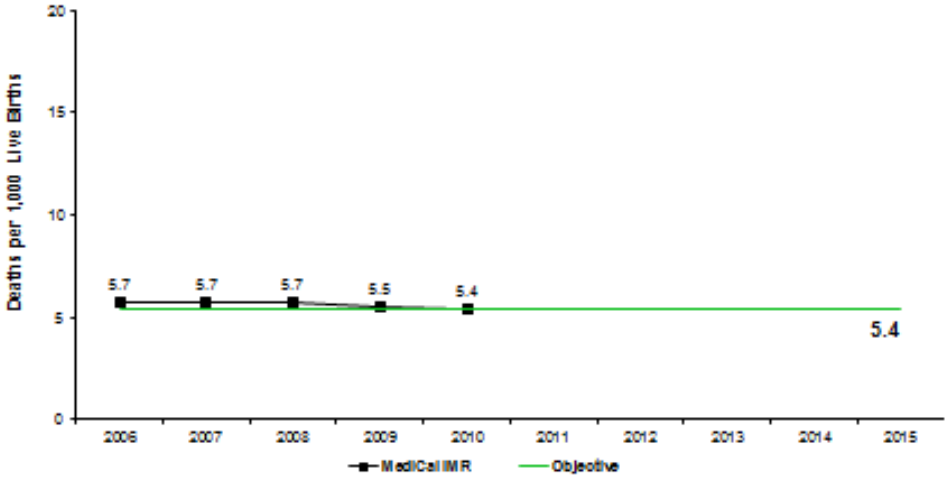
Percent of adolescents reporting a high level of school connectedness



Data source: California Healthy Kids Survey

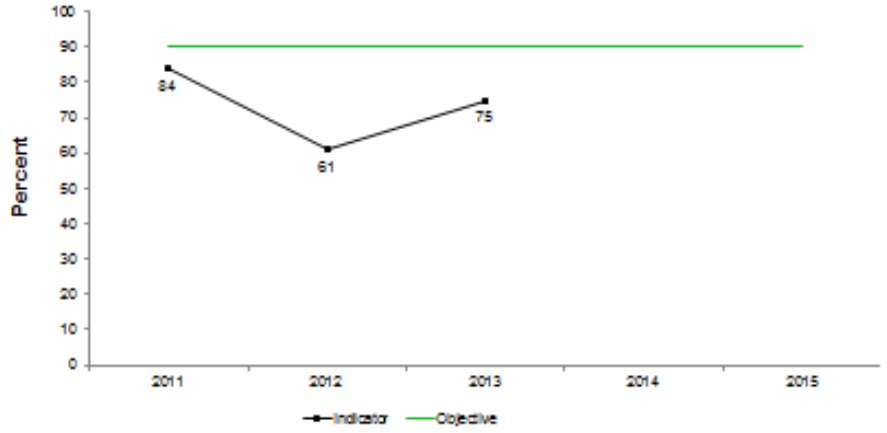
State Performance Measure 9

Low-income infant mortality rate



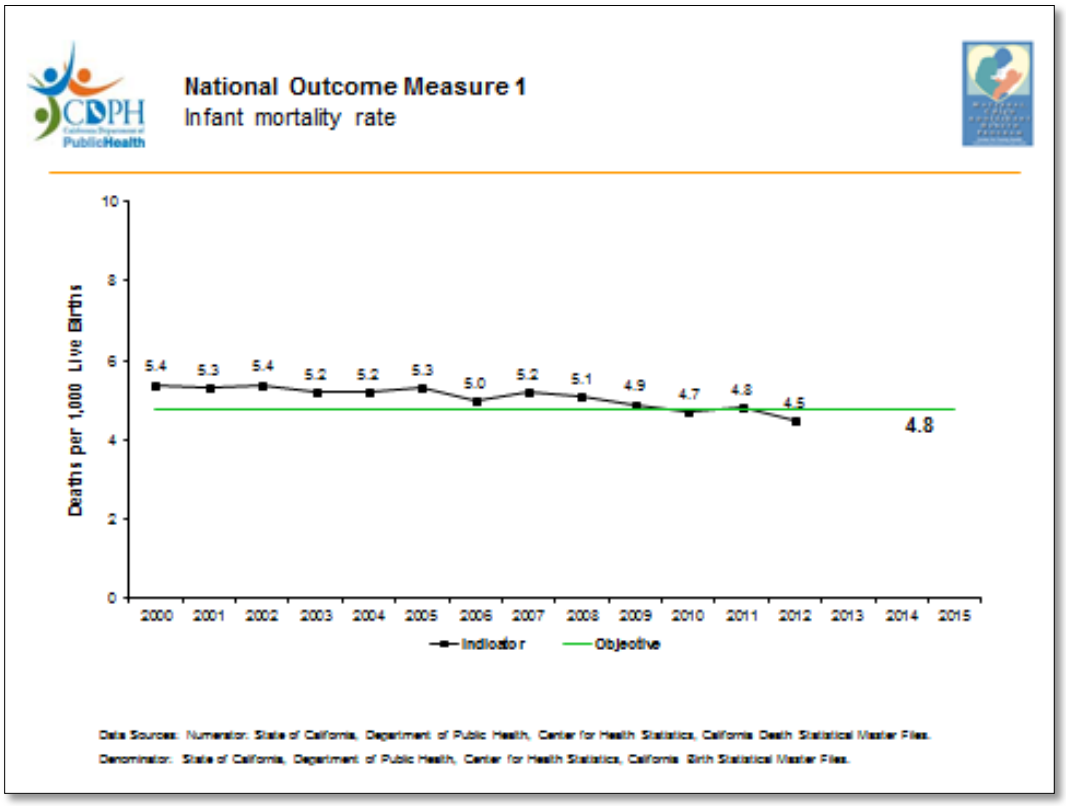
Data source: State of California, Department of Public Health, Center for Health Statistics, Birth Cohort Files.
Infant mortality rate among MediCal recipients.

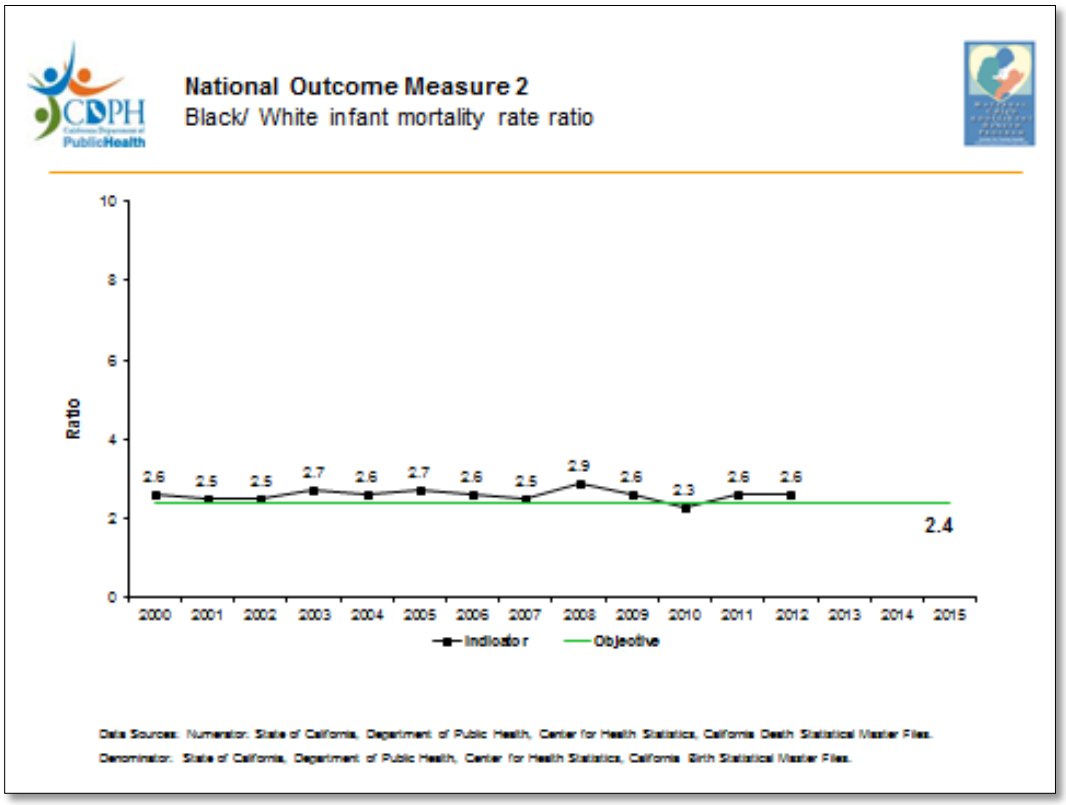
State Performance Measure 10 (active starting 2011)
The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home



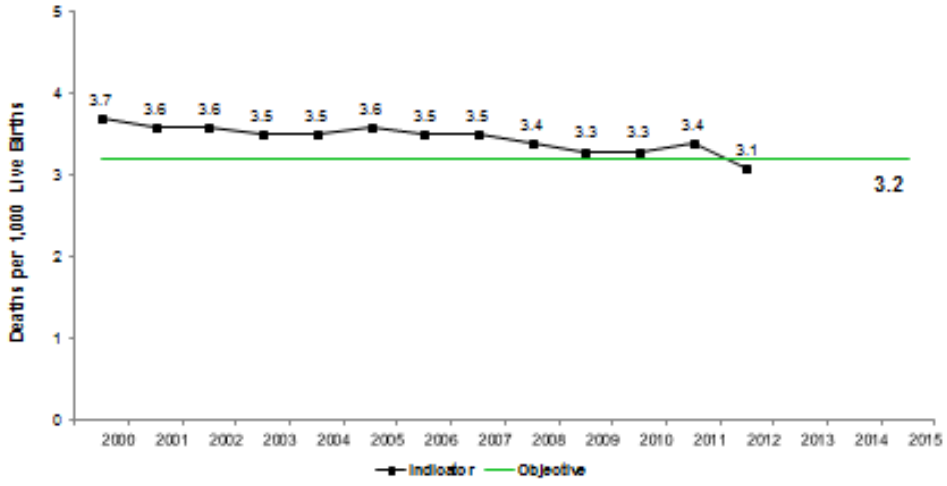
Data source: CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2008-09

National Outcome Measures



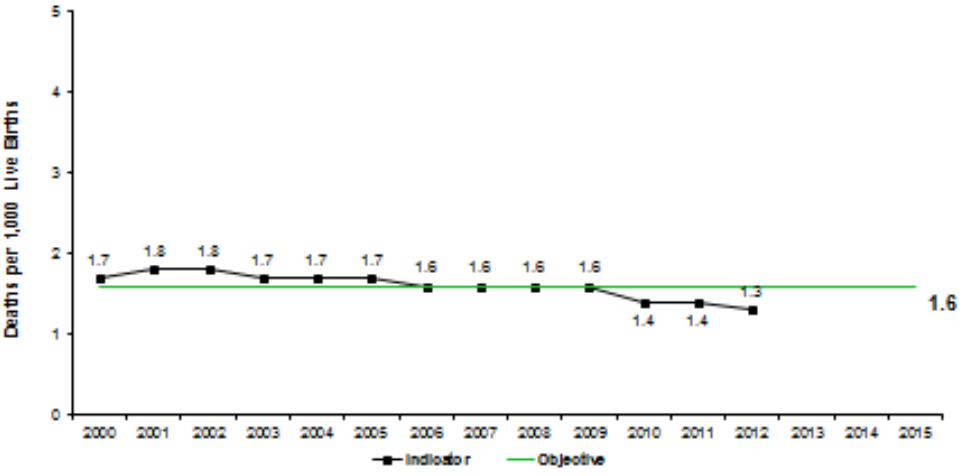


National Outcome Measure 3
Neonatal mortality rate



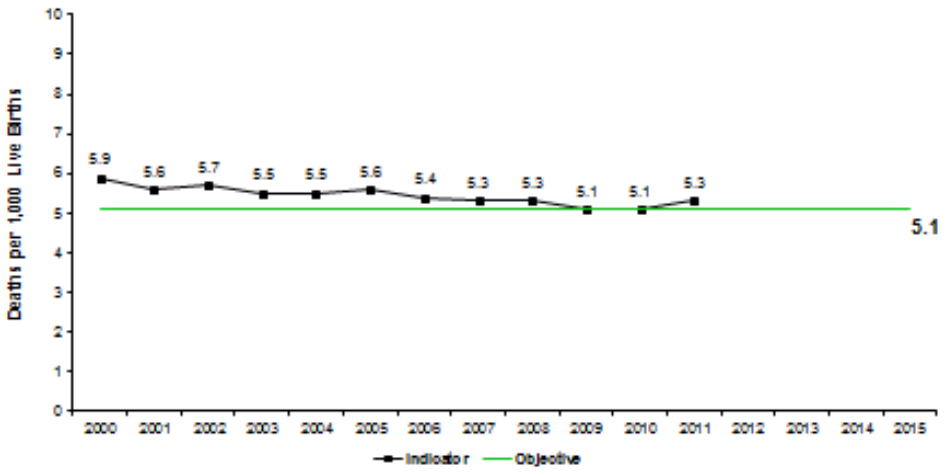
Data sources: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Death Statistical Master Files. Denominator: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master Files.
Note: Neonatal Mortality: Deaths < 28 days

National Outcome Measure 4
Postneonatal mortality rate



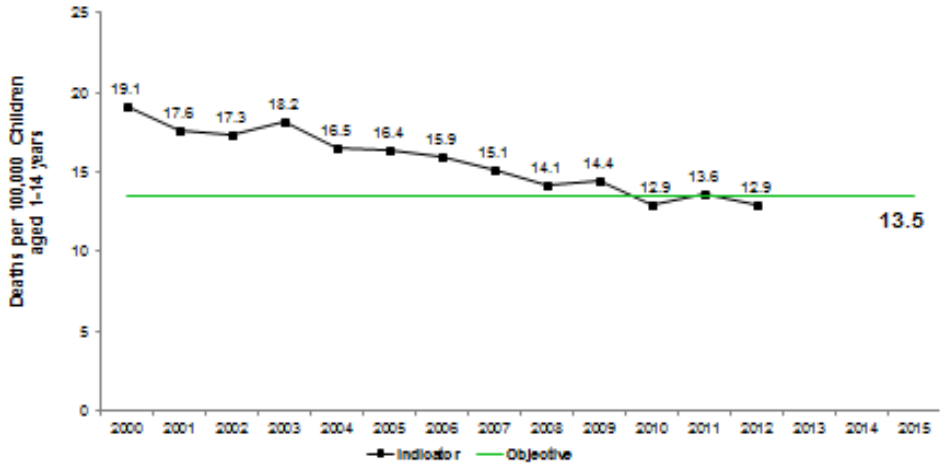
Data Source: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Death Statistical Master Files. Denominator: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master Files.
Note: Post-Neonatal Infant Mortality: Deaths 28 days to 1 year of age.

National Outcome Measure 5
Perinatal mortality rate



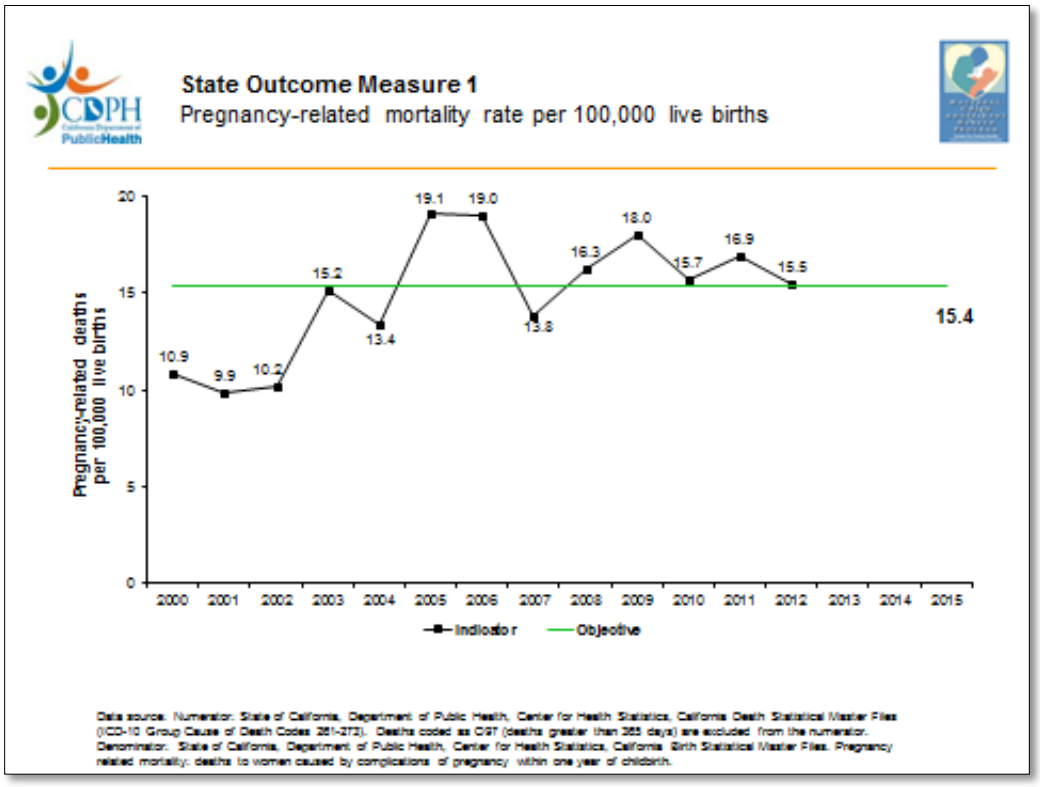
Data source: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Fetal Death Files and Death Statistical Master Files. Denominator: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master Files and California Fetal Death Files. Note: Perinatal Mortality: Stillbirths and deaths to 1 week of age.

National Outcome Measure 6
Death rate per 100,000 children 1-14 years of age

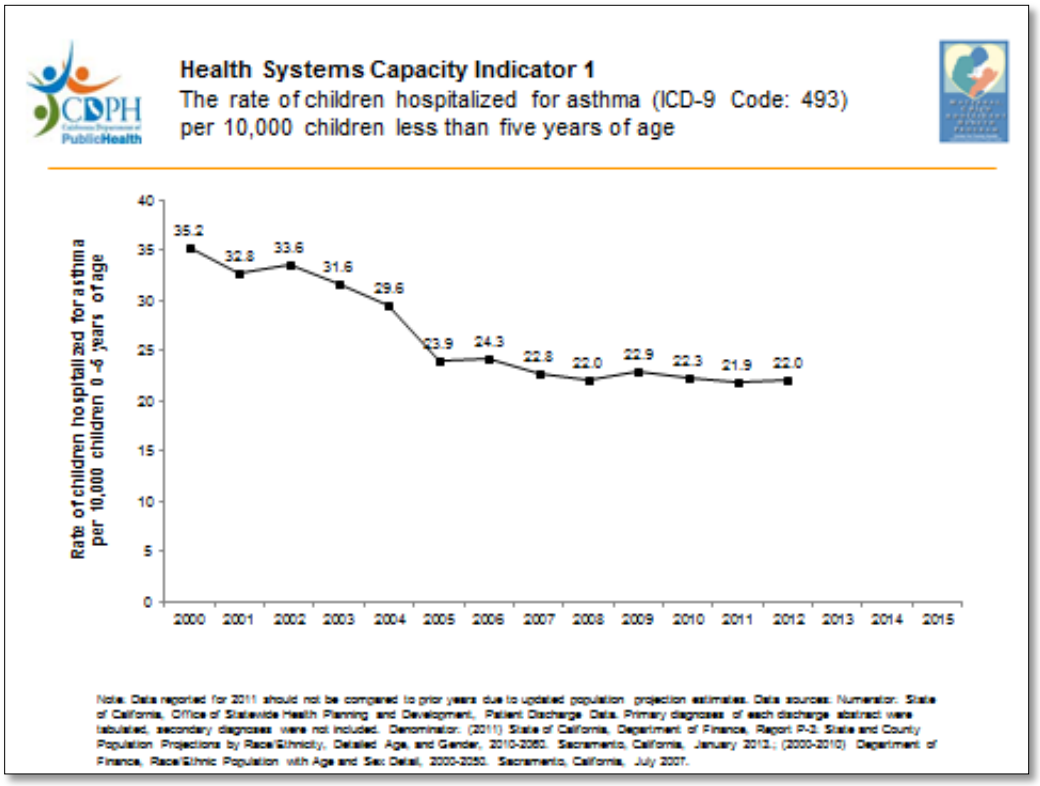


Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data source: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Death Statistical Master Files. Denominator: (2011) State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.; (2000-2010) State of California, Department of Finance, Race/Ethnic Population w/Age & sex Detail, 2000-2050, July 2007.

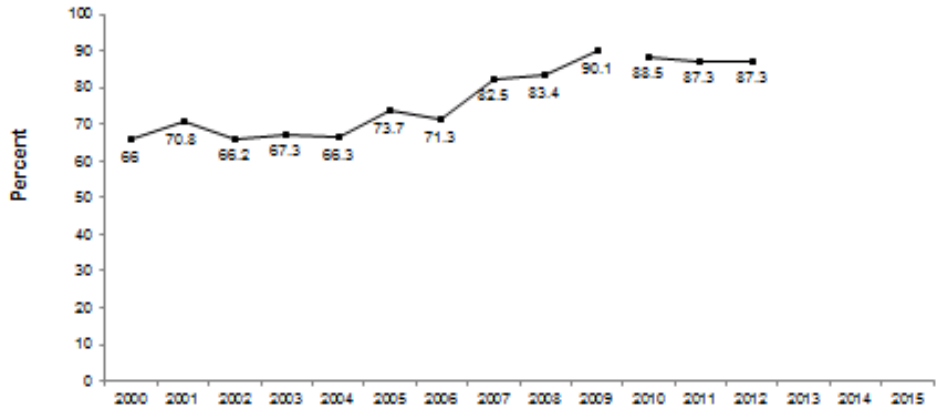
State Outcome Measure



Health Systems Capacity Indicators



Health System Capacity Indicator 2
The percent of Medicaid enrollees < 1 year of age that received an initial periodic screen



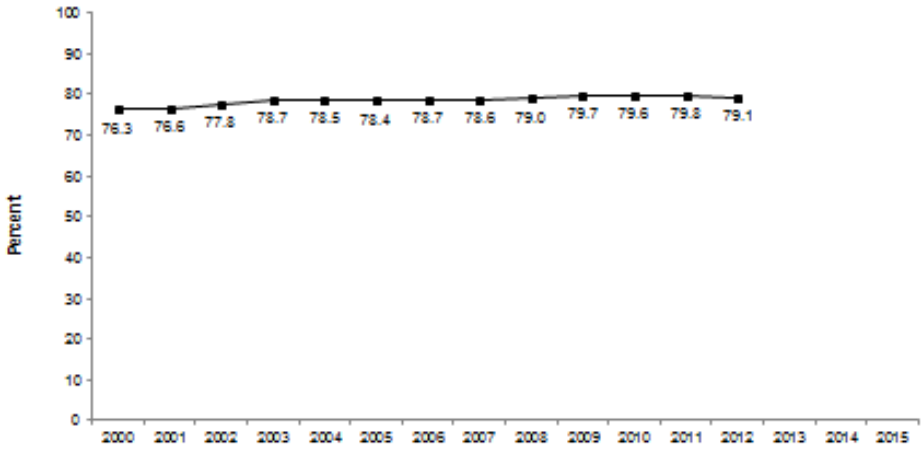
Data source: For 2010, Form CMS-416 Annual EPSDT Participation Report; for prior years, CHDP program data and Medi-Cal.

Health Systems Capacity Indicator 3
The percent of SCHIP (Healthy Families) enrollees whose age is less than one year during the reporting year who received at least one periodic screen

Chart intentionally omitted

Health Systems Capacity Indicator 4

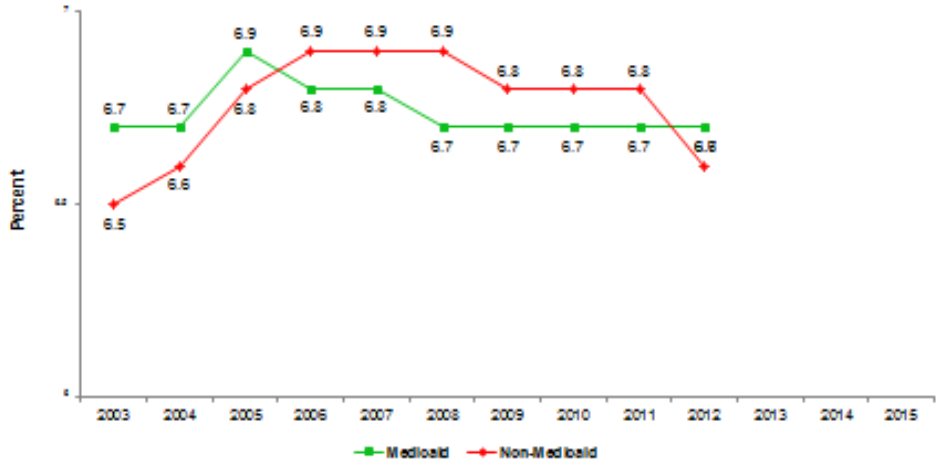
The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index



Data source: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master Files.
Birth records with missing information in prenatal care or visits fields were excluded from the analyses.

Health Systems Capacity Indicator 5A

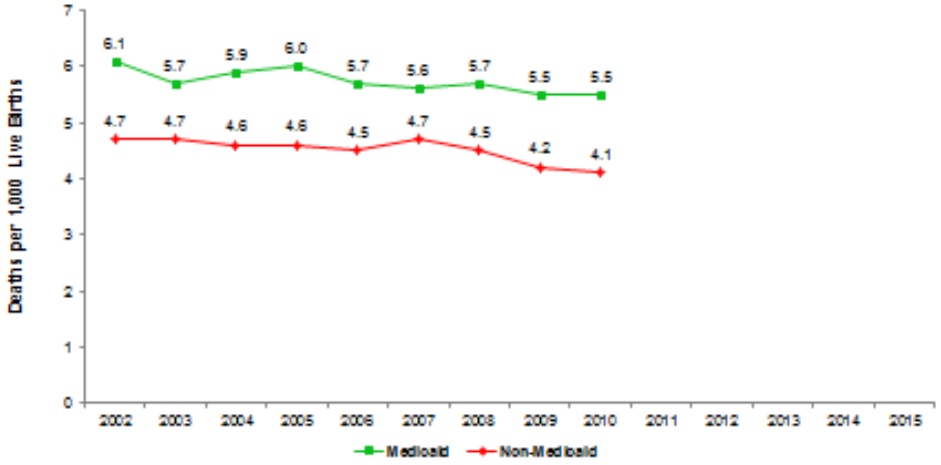
Percent of low birth weight (<2500 grams)



Data source: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master Files.
Expected payer source for delivery was used. Births with unknown birthweight or births weighing <227g or >8165g were excluded when calculating percentages.

Health Systems Capacity Indicator 5B

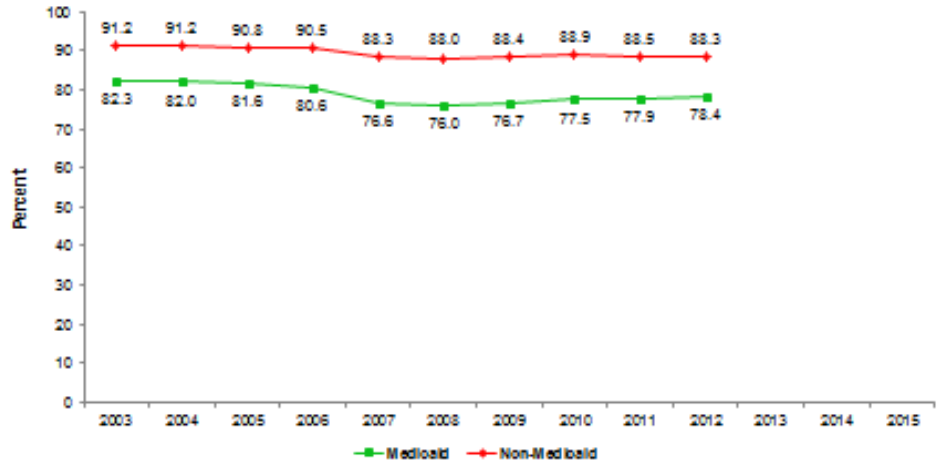
Infant deaths per 1,000 live births



Data source: State of California, Department of Public Health, Center for Health Statistics, Birth Cohort files.

Health Systems Capacity Indicator 5C

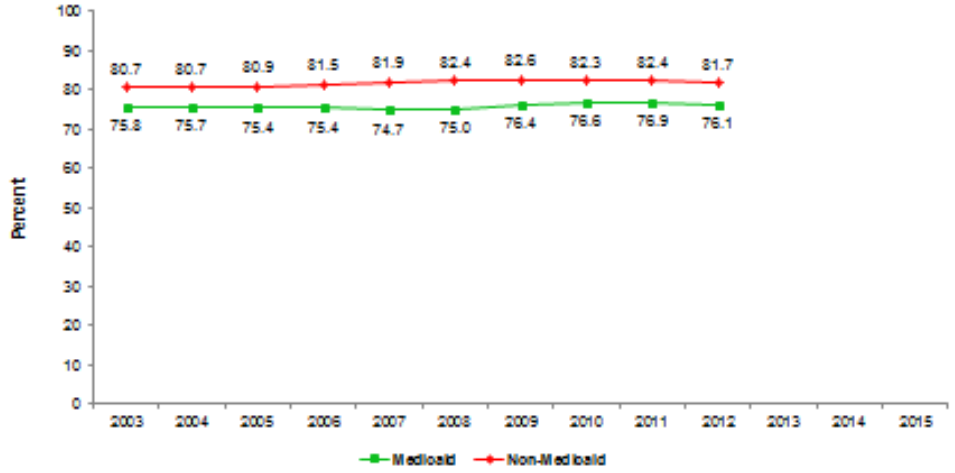
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester



Data source: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master File.
Payer source for prenatal care was used. Birth records with missing prenatal care values were excluded from the analyses.

Health Systems Capacity Indicator 5D

Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])



Data source: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master Files.
Payer source for prenatal care was used. Birth records with missing information in prenatal care initiation or visits fields were excluded from the analyses.

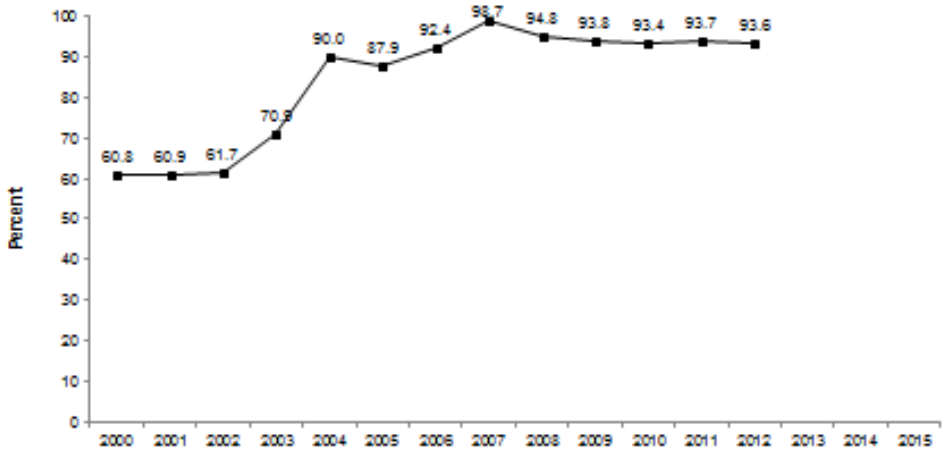
Health Systems Capacity Indicator 6

The percent of poverty level for eligibility in SCHIP (Healthy Families)/ Medi-Cal

Chart intentionally omitted

Health Systems Capacity Indicator 7A

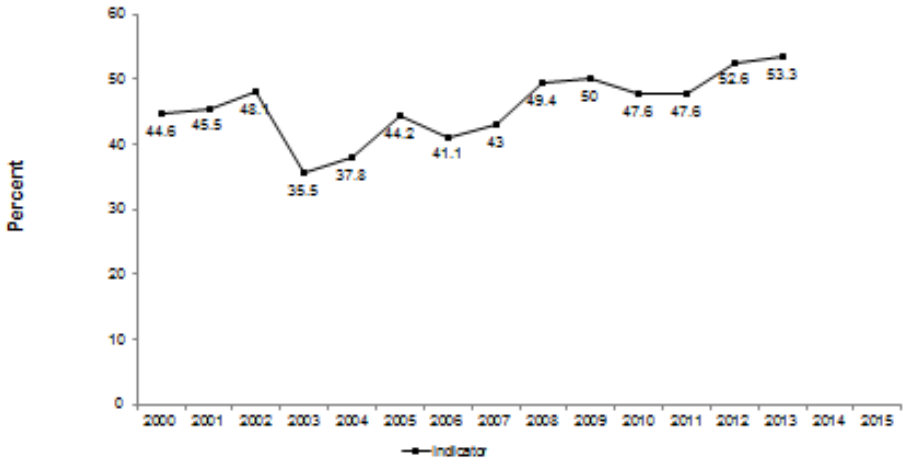
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program



Data source: California Department of Health Care Services, Fiscal Forecasting and Data Management Branch

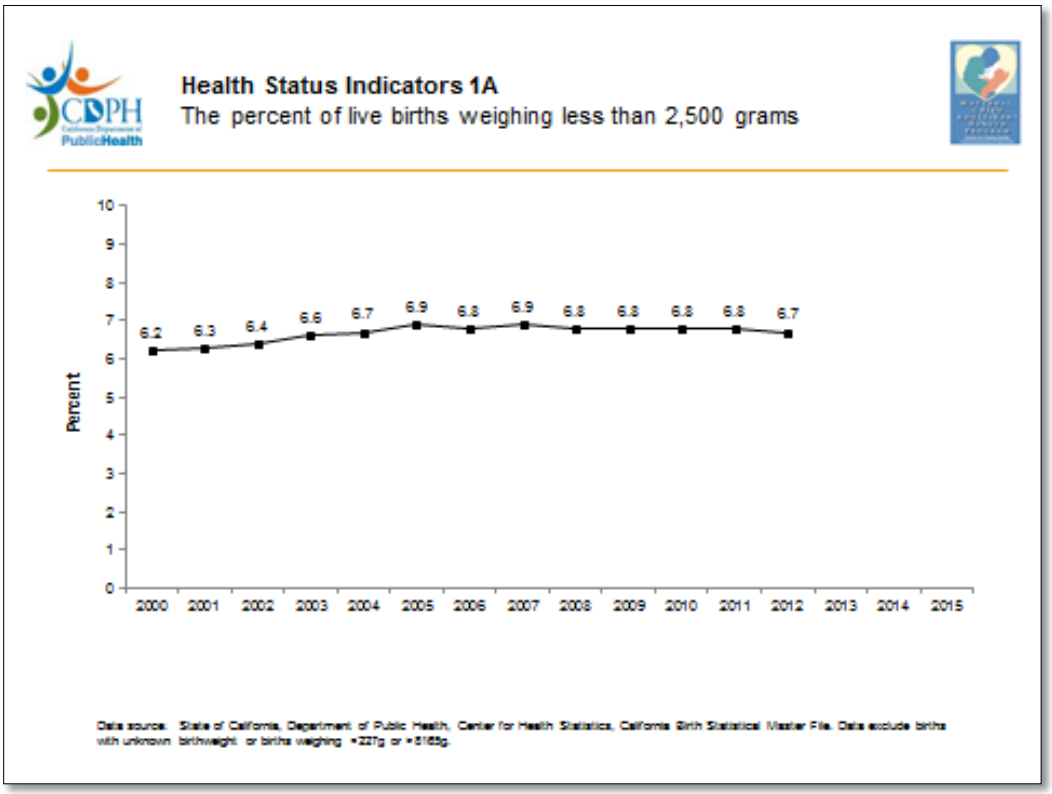
Health Systems Capacity Indicator 7B

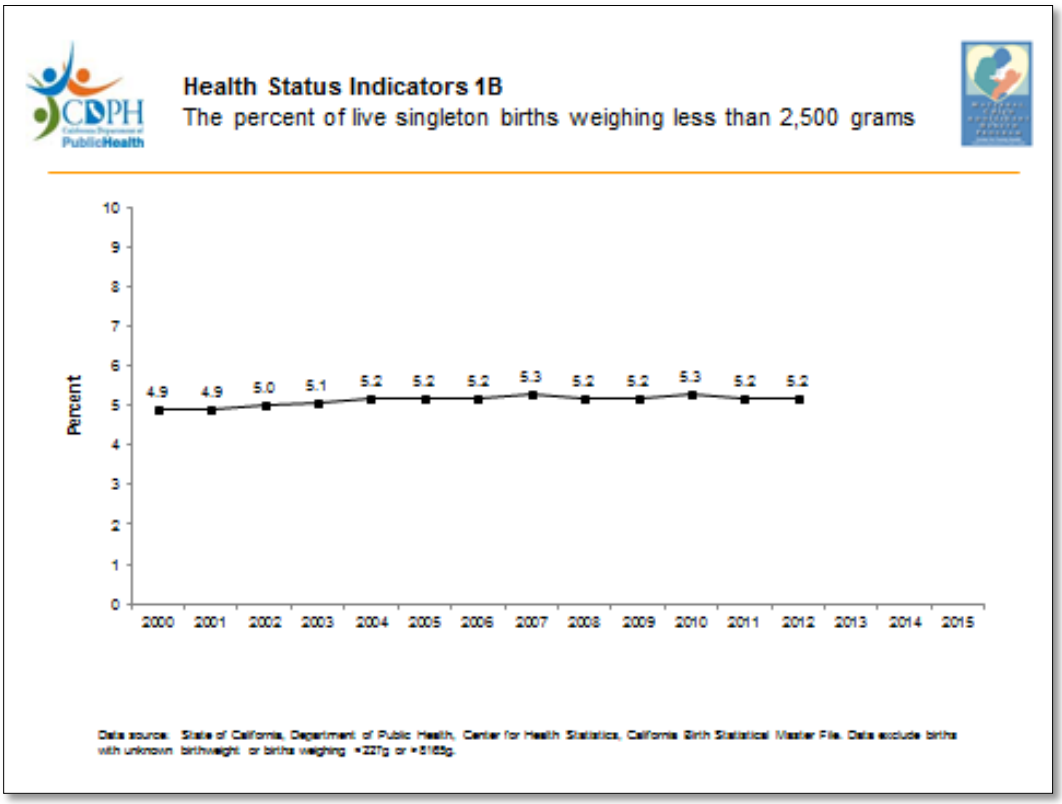
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year

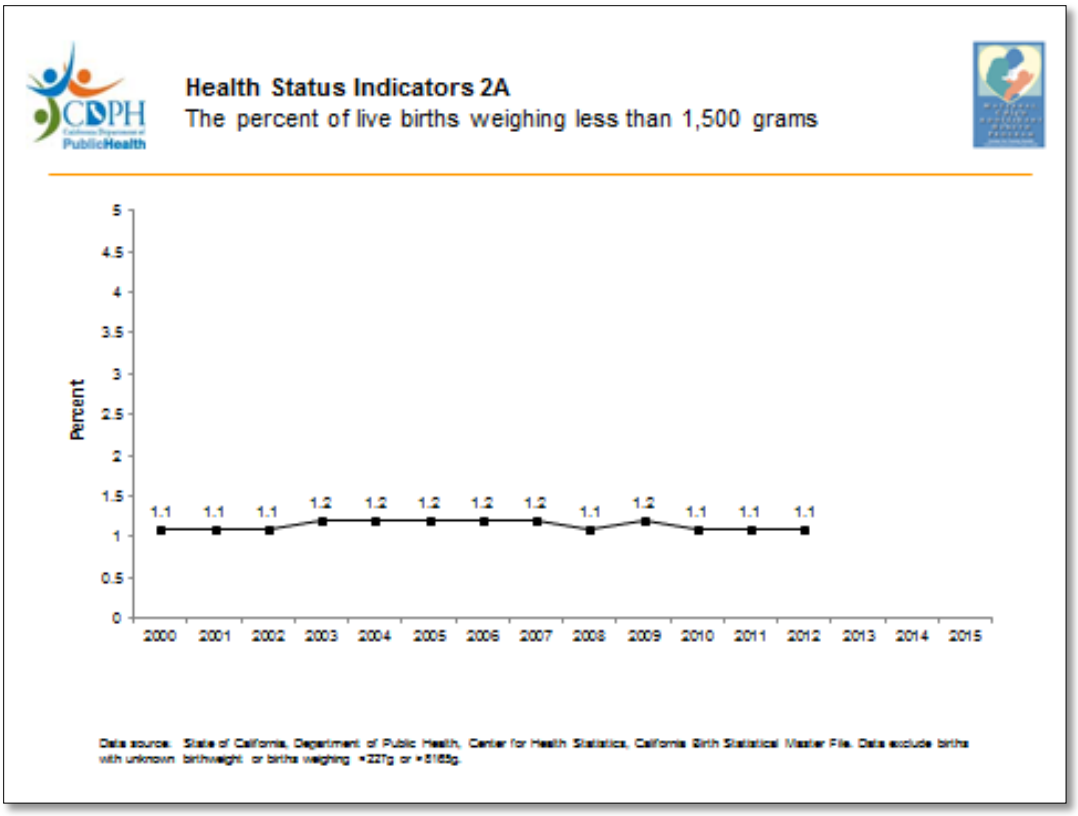


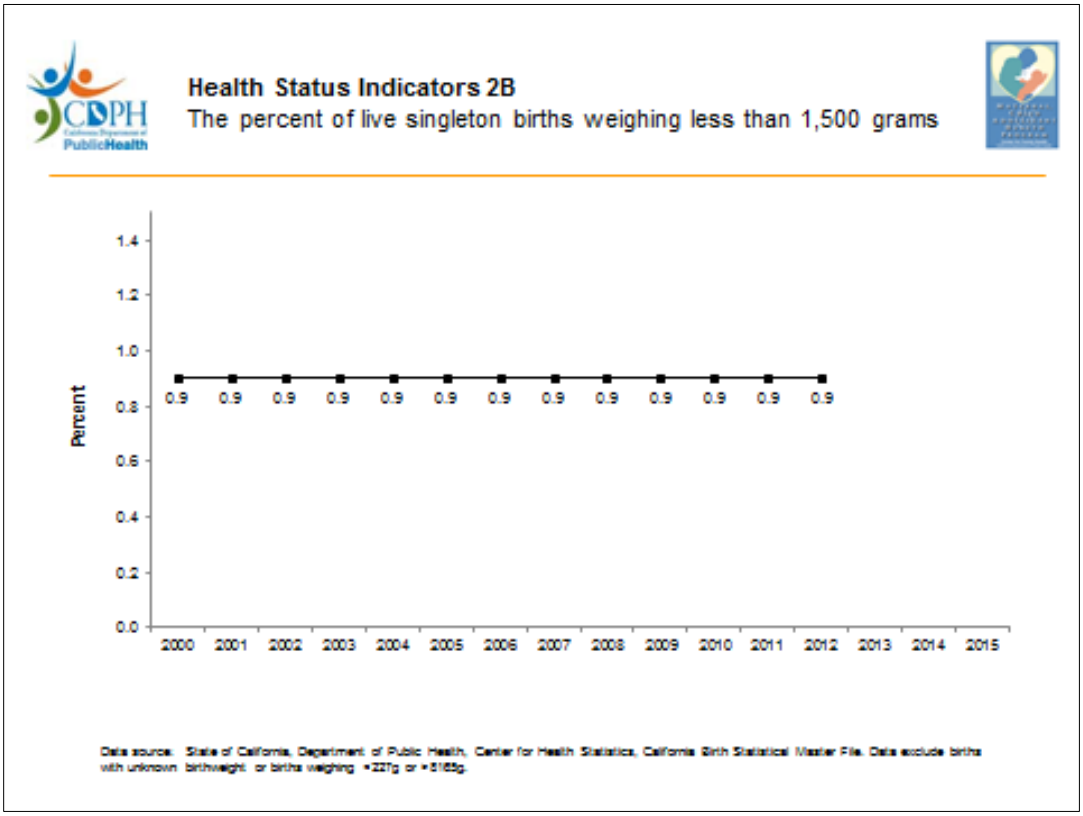
Data source: revised HCFA-416 Form

Health Status Indicators



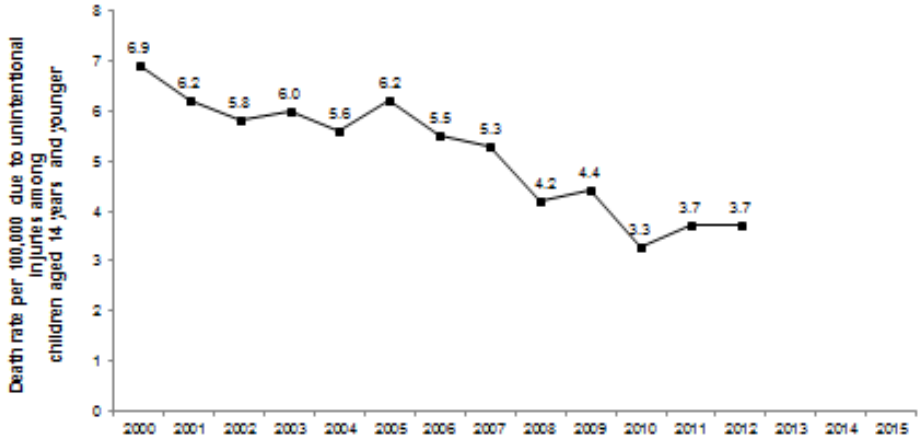



Health Status Indicators 2A
The percent of live births weighing less than 1,500 grams
Percent
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
1.1 1.1 1.1 1.2 1.2 1.2 1.2 1.2 1.1 1.2 1.1 1.1 1.1
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015
Data source: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master File. Data exclude births with unknown birthweight or births weighing <227g or >8165g.


Health Status Indicators 2B
The percent of live singleton births weighing less than 1,500 grams
Percent
1.4
1.2
1.0
0.8
0.6
0.4
0.2
0.0
0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015
Data source: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master File. Data exclude births with unknown birthweight or births weighing <227g or >8165g.

Health Status Indicators 3A

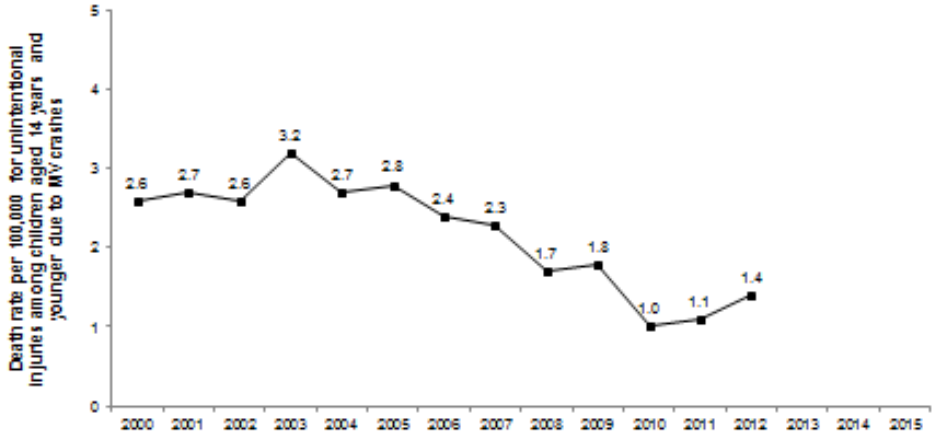
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger



Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data sources: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Death Statistical Master File (ICD-10 Group Cause of Death Codes 295-330. Denominator: (2011) State of California, Department of Finance, Report P-3, State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.; (2000-2010) State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Health Status Indicator 3B

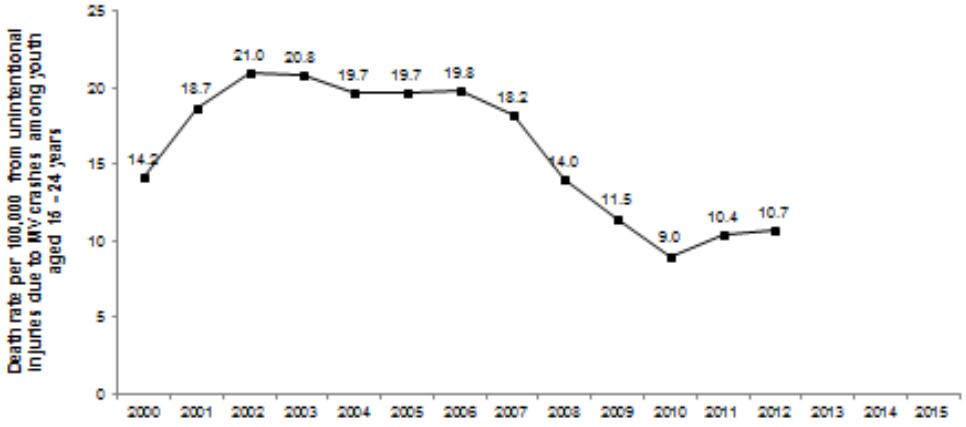
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes



Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data sources: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Death Statistical Master File (The ICD-10 codes for fatal MV traffic injuries are: V20-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V25(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2). Denominator: (2011) State of California, Department of Finance, Report P-3, State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.; (2000-2010) State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Health Status Indicators 3C

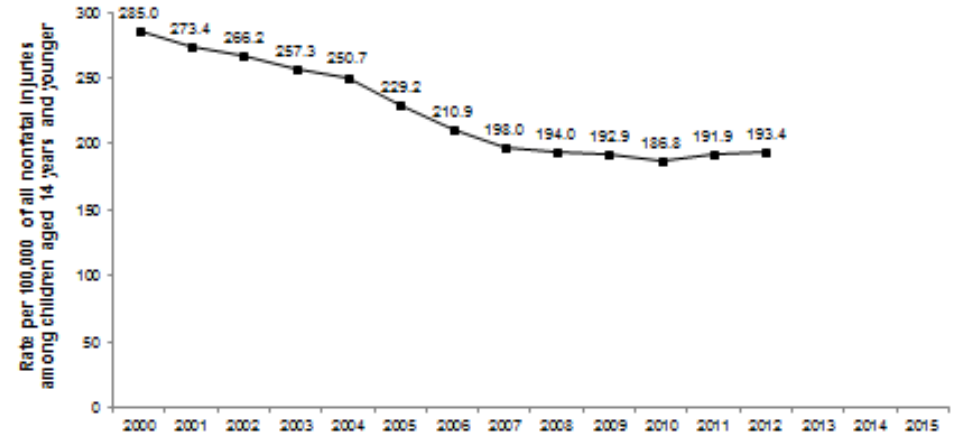
The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years



Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data sources: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Death Statistical Master File (The ICD-10 codes for fatal MV traffic injuries are: V20-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2). Denominator: (2011) State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.; (2000-2010) State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007.

Health Status Indicators 4A

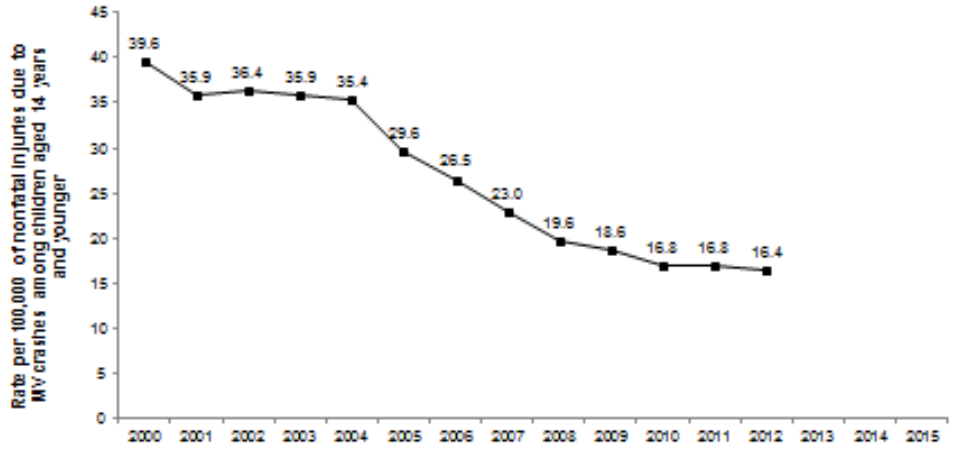
The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger



Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data sources: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data. Principal external cause of injury codes were used (E800-E999). Data exclude cases with iatrogenic codes (adverse effects of medical care and drugs), unknown age, newborns, persons who died in the hospital, and records erroneously listing a "place of injury" code (E849.0-E849.9) as the principal code. Denominator: (2011) State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.; (2000-2010) Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Health Status Indicators 4B

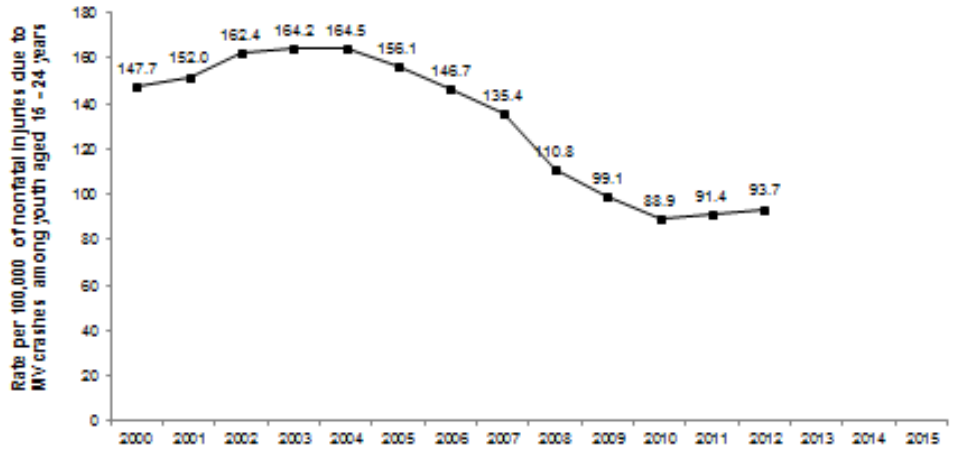
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger



Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data sources: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases of unknown age, newborns, and persons who died in the hospital. Denominator: (2011) State of California, Department of Finance, Report P-3, State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.; (2000-2010) Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Health Status Indicators 4C

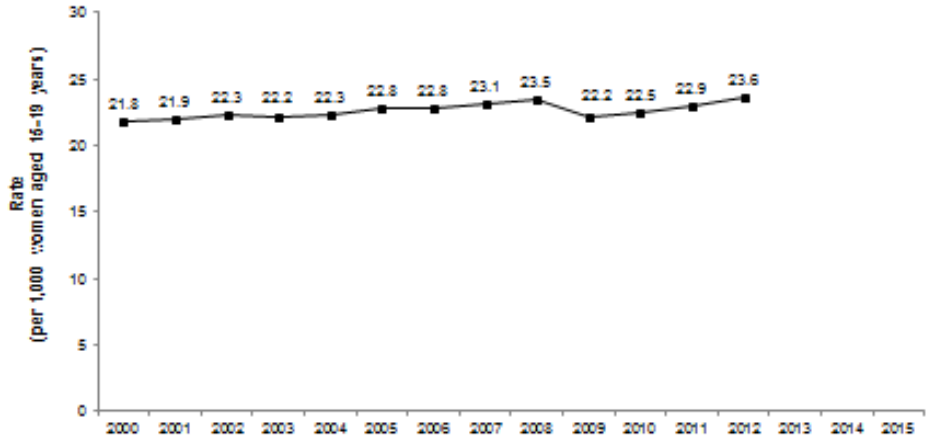
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years



Note: Data reported for 2011 should not be compared to prior years due to updated population projection estimates. Data sources: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude persons who died in the hospital. Denominator: (2011) State of California, Department of Finance, Report P-3, State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.; (2000-2010) Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Health Status Indicators 5A

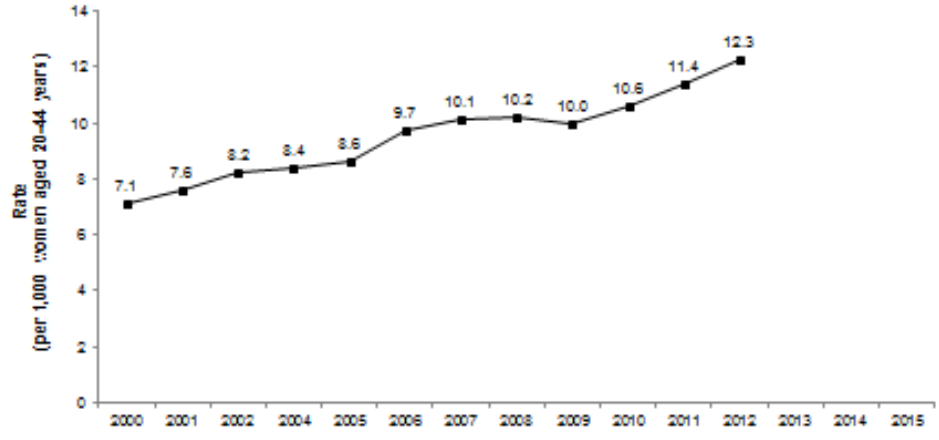
The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia



Data source: California Department of Public Health, STD Branch, Chlamydia, Cases and Rates by Race/Ethnicity, Gender and Age Group

Health Status Indicator 5B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia



Data source: California Department of Public Health, STD Branch, Chlamydia, Cases and Rates by Race/Ethnicity, Gender and age group

ATTACHMENT:
Endnotes and Glossary of Acronyms and Abbreviations

Glossary of Acronyms and Abbreviations

A	AAP-CA	California District of the American Academy of Pediatrics
	AB	Assembly Bill
	ABCD	Assuring Better Child Health and Development
	ACA	Affordable Care Act of 2010
	ACF	Administration of Children and Families
	ACIP	Advisory Committee on Immunization Practices
	ACOG	American Congress of Obstetricians and Gynecologists
	ADP	Alcohol and Drug Program
	AFLP	Adolescent Family Life Program
	AI/AN	American Indian or Alaskan Native
	AIDS	Acquired Immune Deficiency Syndrome
	AIIHI	American Indian Infant Health Initiative
	AIM	Access for Infants and Mothers
	ALIP	AIM Linked Infants Program
	AMCHP	Association of Maternal and Child Health Programs
	ARB	Air Resources Board
	ASHWG	Adolescent Sexual Health Work Group
	ASPHN	Association of State Public Health Nutritionists
	ASRH	Adolescent Sexual and Reproductive Health
	ASTPHND	Association of State and Territorial Public Health Nutrition Directors
B	BBC	Birth and Beyond California
	BIH	Black Infant Health
	BMI	Body Mass Index
C	CA	State of California
	CAA	Certified Application Assisters (for Medi-Cal & Healthy Families)
	CAHC	California Adolescent Health Collaborative
	CalWORKS	California's cash assistance program for children and families
	Cal-SAFE	California School Age Families Education
	CAN	California Association of Neonatologists
	CBDMP	California Birth Defects Monitoring Program
	CBO	Community Based Organization
	CCDPHP	Center for Chronic Disease Prevention and Health Promotion
	CCG	Community Challenge Grant
	CCHA	California Children's Hospital Association
	CCHD	Critical Congenital Heart Disease Screening
	C-CHIP	County Children’s Health Initiative Program
	CCLHO	California Conference of Local Health Officers
	CCS	California Children’s Services
	CDAPP	California Diabetes and Pregnancy Program
	CDC	Centers for Disease Control and Prevention

	CDE	California Department of Education
	CDPH	California Department of Public Health
	CDRT	Child Death Review Team
	CFH	Center For Family Health
	CFHC	California Family Health Council
	CHDP	Child Health and Disability Prevention
	CHHSA	California Health and Human Services Agency
	CHI	Children's Health Initiatives
	CHIIP	California Health Incentives Improvement Project
	CHVP	California Home Visiting Program
	CIPPP	Center for Injury Prevention Policy and Practice
	CLABSI	Central Line Associated Blood Stream Infections
	CLPP	Childhood Lead Poisoning Prevention program
	COPP	California Obesity Prevention Program
	CMQCC	California Maternal Quality Care Collaborative
	CMS	Children's Medical Services
	CPeTS	California Perinatal Transport Systems
	CPQCC	California Perinatal Quality Care Collaborative
	CPSP	Comprehensive Perinatal Services Program
	CPS	Child Passenger Safety
	CRISS	Children's Regional Integrated Service Systems
	CSCC	Children's Specialty Care Coalition
	CSHCN	Children with Special Health Care Needs
	CSUS	California State University, Sacramento
	CTCP	California Tobacco Control Program
	CVS	Chorionic Villus Sampling
	CWA	California WIC Association
	CYSHCN	Children and Youth with Special Health Care Needs
D	DDS	Department of Developmental Services
	DHCS	Department of Health Care Services
	DHF	Dental Health Foundation
	DMH	Department of Mental Health
	DMS	Data Management Service
	DSS	Department of Social Services
E	EAPD	Epidemiology, Assessment and Program Development
	ECCS	Early Childhood Comprehensive Systems
	ELL	English Language Learner
	EPSDT	Early and Periodic Screening, Diagnosis and Treatment
F	Family PACT	Family Planning, Access, Care & Treatment
	FASD	Fetal Alcohol Spectrum Disorder

	FCC	Family Centered Care
	FFY	Federal Fiscal Year (October 1 - September 30)
	FHOP	Family Health Outcomes Project
	FIMR	Fetal Infant Mortality Review
	FMCO	Fiscal Management and Contract Operations
	FPL	Federal Poverty Level
	FQHC	Federally Qualified Health Clinic
	FRC	Family Resource Center
	FTE	Full-time equivalent
	FVCA	Family Voices of California
	FY	State Fiscal Year (July 1 - June 30)
G	GDSP	Genetic Disease Screening Program
	GHPP	Genetically Handicapped Persons Program
	GIS	Geographic Information System
H	HBV	Hepatitis B vaccine
	HBEX	Health Benefit Exchange
	HCC	Hearing Coordination Center
	HCG	Human Chorionic Gonadotropin
	HCP	Hearing Conservation Program
	HCPCFC	Health Care Program for Children in Foster Care
	HEDIS	Health Plan Employer Data and Information Set
	HF	Healthy Families -- California's State Children's Health Insurance Program
	HeAPA	Health-e-App Public Access
	HIV	Human Immunodeficiency Virus
	HRIF	High Risk Infant Follow-up
	HRSA	Health Resources and Services Administration
	HSCI	Health Status Capacity Indicator
	HSCR	Human Stem Cell Research
	HSI	Health Status Indicator
	HV	Home Visiting Program
I	I&E	Information and Education Program
	ICD	International Classification of Diseases
	ICPC	Interconception Care Project of California
	IHI	Institute for Healthcare Improvement
	IPODR	Improved Perinatal Outcome Data Reports
	ITS	Information Technology Section
	IZB	Immunization Branch, CDPH
K	KASA	Kids as Self Advocates
L	L.A.	Los Angeles

	LAMH	Local Assistance to Maternal Health
	LAPSNC	Los Angeles Partnership for Special Health Care Needs Children
	LBW	Low Birth weight (<2500 grams)
	LHDMP	Local Health Department Maternal Child and Adolescent Health Program
	LHJ	Local Health Jurisdiction
M	MCAH	Maternal, Child, and Adolescent Health
	MCHB	Maternal and Child Health Bureau (Federal Agency)
	MCMC	Medi-Cal Managed Care
	MEDS	Medi-Cal Eligibility Data System
	MHF	Maternal Health Framework
	MHSA	Mental Health Services Act
	MIG	Medicaid Infrastructure Grant
	MIHA	Maternal and Infant Health Assessment
	MIS	Management Information Services
	MOD	March of Dimes
	MPINC	Maternity Practices in Infant Nutrition and Care Survey
	MQI	Maternal Quality Improvement
	MRMIB	Managed Risk Medical Insurance Board
	MTP	Medical Therapy Program
N	NBS	Newborn Screening
	NCHS	National Center for Health Statistics
	NHSP	Newborn Hearing Screening Program
	NICU	Neonatal Intensive Care Unit
	NIPT	Non-Invasive Prenatal Testing
	NPM	National Performance Measure
	NQI	National Quality Improvement
	NT	Nuchal Translucency
	NTD	Neural Tube Defect
O	OCAP	Office of Child Abuse Prevention
	OFP	Office of Family Planning
	OHAC	Oral Health Access Council
	OHC	Other Health Coverage
	OHU	Oral Health Unit
	OPG	Obesity Prevention Group
	OSHPD	Office of Statewide Health Planning and Development
	OTech	Office of Technology Services
Children's Program	OT	Occupational Therapy
	OTS	Office of Traffic Safety
	OVR	Office of Vital Records

P	PAF	Pregnancy Assistance Fund
	PAIS	Program Allocation, Integrity and Support
	PAMR	Pregnancy-Related and Pregnancy-Associated Mortality Review
	PAOPP	Physical Activity and Obesity Prevention Program
	PCC	Pediatric Critical Care
	PCP	Primary Care Physician
	PDD	Patient Discharge Data
	PDN	Private Duty Nursing
	PDS	Program Development Section
	PDHC	Pediatric Day Health Care
	PedNSS	Pediatric Nutrition Surveillance System
	PFC	Partners For Children
	PHCC	Preconception Health Council of California
	PHHI	Preconception Health and Healthcare Initiative
	PHL	Parent Health Liaison
	PHN	Public Health Nurse
	PHP	Partnership Health Plan
	PICU	Pediatric intensive care unit
	PKU	Phenylketonuria
	PPC	Pediatric Palliative Care
		Pediatric Palliative Care Waiver
	PPE	Preconception Peer Educators
	PQIP	Perinatal Quality Improvement Panel
	PRAMS	Pregnancy Risk Assessment Monitoring System
	PRISM	Pediatric Risk of Mortality
	PSA	Public Service Announcement
	PSS	Program Support Section
	PSU	Provider Services Unit
	PT	Physical Therapy
	PYD	Positive Youth Development
Q	QCI	Quality of Care Initiative
	QI	Quality Improvement
R	RCA	Regional Cooperative Agreements
	RFAs	Requests for Applications
	RFP	Request for Proposal
	RLP	Reproductive Life Planning
	ROS	Regional Operations Section
	RPPC	Regional Perinatal Programs of California
	RTT-ELC	Race to the Top-Early Learning Challenge
S	SAC	Safe and Active Communities
	SARs	Service Authorization Requests

	SCCs	Special Care Centers
	SCD	Systems of Care Division
	SCHIP	State Children's Health Insurance Program
	SCOTS	Statewide Coalition on Traffic Safety
	SDSU	San Diego State University
	SIDS	Sudden Infant Death Syndrome
	SIT	State Interagency Team
	SOW	Scope of Work
	SPM	State Performance Measure
	SPS	Statewide Programs Section
	SSC	State Screening Collaborative
	STD	Sexually Transmitted Disease
T	TA	Technical Assistance
	TANF	Temporary Assistance to Needy Families
	TWG	technical workgroups
U	UCB	University of California, Berkeley
	UCEDD	University Center for Excellence in Developmental Disabilities
	UCLA	University of California, Los Angeles
	UCSF	University of California, San Francisco
V	VFC	Vaccines for Children
	VLBW	Very Low Birth weight (<1500 grams)
W	WIC	Women, Infants, and Children Supplemental Nutrition Program
	WHO	World Health Organization
Y	YSHCN	Youth with Special Health Care Needs

References

1. California Department of Finance and Economic Research Unit, *California Statistical Abstract*. 2009, CA Department of Finance: Sacramento, CA.
2. Berry, R.J., et al., *Prevention of neural-tube defects with folic acid in China. China-U.S. Collaborative Project for Neural Tube Defect Prevention.* N Engl J Med, 1999. **341**(20): p. 1485-90.
3. California Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000-2050*. July, 2007, CA Department of Finance: Sacramento, CA.
4. California First 5 California Children and Families Commission, *Research Identifying Hard to Reach Communities*, California First 5 California Children and Families Commission: Sacramento, CA.
5. California Department of Finance, *Population Projections for California and Its Counties 2000-2050*. July, 2007, California Department of Finance: Sacramento, CA.
6. Ventura S.J., T.J.M., and B.E. Hamilton,, *Births to teenagers in the United States, 1940-2000.* National Vital Statistics Reports, 2001, 2001: p. 10.
7. Hoffman, S.D., ed. *Kids having kids: Economic costs and social consequences of teen pregnancy*. . 2008, The Urban Institute Press.
8. U.S. Census Bureau and American Community Survey, *Selected Social Characteristics in the United States, 2006-2008 American Community Survey 3-Year Estimates*. 2008, U.S. Census: Washington, DC.
9. California Department of Public Health, *Birth Statistical Master File (BSMF)*. 2008, California Department of Public Health: Sacramento, CA.
10. Fortuny K., R.C., and R. Passel (March 2007) *Unauthorized immigrants in California, Los Angeles County, and the United States*.
11. Passel, J.S. and D. Cohn, *A Portrait of unauthorized immigrants in the United States*. April 14, 2009, Pew Hispanic Center: Washington, D.C.
12. Hill, L.E. and H.P. Johnson. *Unauthorized Immigrants in California, Estimates for Counties.* 2011 [cited Available from: http://www.ppic.org/content/pubs/report/R_711LHR.pdf Accessed on May 11, 2012.
13. California Department of Education, E.D.O., and CBEDS data collection, *Enrollment, Graduates and Dropouts in California Public Schools, 1974-75 Through 2007-2008. 2010.*
14. California Department of Education and Eucational Demographics Office, *Dropouts by Ethnic Designation by Grade, State of California for the Year 2007-08*. 2007-08, California Department of Education: Sacramento, CA.
15. Rumberger, R. and S. Rotermund, *Ethnic and Gender Differences in California High School Graduation Rates*, in *California Dropout Research Project*. 2010, Gervitz Graduate School of Education, University of California, Santa Barbara: Santa Barbara, CA.
16. California Department of Education, E.D.O., and CBEDS data collection, *Enrollment, Graduates and Dropouts in California Public Schools, 1974-75 Through 2009-2010*. . 2010.

17. U.S. Census Bureau and American Community Survey, *Selected Social Characteristics in the United States, 2006-2008 American Community Survey 3-Year Estimates. 2008,* : U.S. Census: Washington, DC.
18. California Department of Public Health, *County Health Status Profiles 2010*. 2010, California Department of Public Health: Sacramento, California.
19. U.S. Census Bureau and American Community Survey, *B17017. Poverty status in the past 12 months by household type by age of householder, 2006-2008 American Community Survey 3-year Estimates*. 2008, U.S. Census: Washington, D.C.
20. Pearce, D.M., *Overlooked and Undercounted 2009: Struggling to Make Ends Meet in California*. December, 2009, School of Social Work, Center for Women's Welfare, University of Washington.
21. Braveman, P., et al., *Poverty, near-poverty, and hardship around the time of pregnancy.* Matern Child Health J, Volume 14, (1): p. 20-35.
22. Kidsdata.org. and CA Department of Education, *Free/Reduced Price Meals Program & CalWORKS.* (Data Files http://www.cde.ca.gov/ds/sh/cw/filesafdc.asp (Feb. 2012) U.S. Department of Education, NCES Common Core of Data, http://nces.ed.gov/ccd/bat/index.asp (Feb. 2012).Accessed on March 20, 2012.).
23. U.S. Department of Labor and Bureau of Labor Statistics, *Regional and State Unemployment - 2010 Annual Averages.* February 25, 2011, U.S. Department of Labor, Bureau of Labor Statistics.
24. Kolko, J. (January 2011) *Just The Facts: The California Economy: Employment in 2010*.
25. Kaiser Family Foundation. *California: Measures of State Economic Distress: Housing Foreclosures and Changes in Unemployment and Food Stamp Participation*. Available from: http://www.statehealthfacts.org. Accessed on March 20, 2012.
26. The Henry J. Kaiser Foundation and The California Health Landscape. *Kaiser Commission on Medicaid and the Uninsured*. December 2011 [cited Available from: http://www.kff.org/medicaid/upload/8268.pdf. Last accessed on June 5, 2012.
27. Nadereh Pourat, P., et al. (October 22, 2013) *Costs of Gestational Hypertensive Disorders in California: Hypertension, Preeclampsia, and Eclampsia*.
28. California Health and Safety Code, *Section 123225, Available from: http://www.leginfo.ca.gov/calaw.html*. May 15, 2010.
29. National Low Income Housing Coalition. *Out of Reach 2007-2008.* May 15, 2010]; Available from: http://www.nlihc.org/oor/oor2008/data.cfm?getstate=on&state=CA.
30. Rand Corporation and Business and Economic Statistics. *Housing Foreclosure Statistics.* 2010 May 15, 2010]; Available from: http://ca.rand.org/stats/economics/foreclose.html.
31. Kidsdata.org. and The National Center on Family Homelessness, *A State Report Card on Child Homelessness: America's Youngest Outcasts* 2009, The National Center on Family Homelessness: Newton, MA.
32. Kidsdata.org. *Housing Affordability: Selected Facts*. 2009; Available from: [cited May 15, 2010]; Available from: http://www.kidsdata.org/Data/Topic/Dashboard.aspx?gsa=1&cat=41.
33. Foundation, U.H., *America's Health Rankings Custom Report Tool*.
34. Centers for Disease Control and Prevention, *National Environmental Public Health Tracking Network: 2008.*

35. Gruenstein Bocian, D., et al. *Dreams Deferred: Impacts and Characteristics of the California Foreclosure Crisis. 2010.* Available from: Available from: http://www.responsiblelending.org/mortgage-lending/research-analysis/Lost-Ground-2011.pdf Last accessed on May 11, 2012.
36. Constance F. Citro and Robert T. Michael, E., et al., eds. *Measuring Poverty - A New Approach*. Panel on Poverty and Family Assistance: Concepts, Information Needs, and Measurement Methods ed. 1995, National Academy Presss, Washington, D.C.